

Medication-Assisted Treatment and Office-Based Addiction Treatment Attestation Form

New Jersey | Medicaid

Practitioner name:		NPI:	
Tax ID:		Specialty:	<input type="checkbox"/> Primary care physician <input type="checkbox"/> Specialist
Practice name:			
MAT DEA registration number:		MAT DEA expiration date:	
Patients certified for:			
<input type="checkbox"/> 30 <input type="checkbox"/> 100 <input type="checkbox"/> 275 <input type="checkbox"/> Other			

Mark one box only:

- I have a *Drug Addiction Treatment Act of 2000 (DATA 2000)* waiver and provide medication-assisted treatment (MAT). I certify that I will **not** be billing for a navigator under the office-based addiction treatment (OBAT) attestation program and wish to be listed as a MAT provider.
- I have a *DATA 2000* waiver and provide MAT. I certify that I have or will hire a navigator, **will** participate in the OBAT program, and wish to be listed as a MAT provider with navigation (OBAT provider).

Number of navigators in practice: _____

- I do **not** have a *DATA 2000* waiver and cannot provide MAT.

Please briefly describe (or attach to this form) the navigator services that your practice provides:	
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By signing below, I hereby swear or affirm that the above information is correct and that my practice is in compliance with all applicable state and federal laws.

Signed:	
Date:	

Please return this form either:

- Via email at Sandra.Carona@anthem.com
- Via fax at **866-920-5997**