



**State of South Carolina**  
 Department of Health and Human Services

Please return signed original certificate to:  
**Mailing Address:**  
 SC Dept. of Health and Human Services  
 c/o Division of Physician Services  
 Post Office Box 8206  
 Columbia, South Carolina 29202-8206  
 Tel: (803) 898-2660  
 Fax: (803) 255-8255

**Section I: Demographic Information**

Please Print:

<b>Physician Name</b>	
<b>Legacy Provider Number</b>	
<b>NPI Number</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Fax:</b>	
<b>Email:</b>	

**Section II: Attestation Statement Pediatric Anesthesia Services**

I hereby certify that:

1. I am a physician member in good standing on the medical staff of a hospital.
2. I am qualified in and practice as a
  - \_\_\_\_\_ Pediatric intensivist or
  - \_\_\_\_\_ Pediatric emergency room physician.
3. At least 85% of my total practice, including after-hours patients, is dedicated to children age 18 years and under.

I am providing this attestation certificate to the South Carolina Department of Health and Human Services with the request that I be included on the list of pediatric physicians eligible to bill for selected anesthesia services provided to children enrolled in the South Carolina Medicaid program. I hereby certify, under penalty of perjury, that the information provided in this certificate is correct as of the date of this certificate.

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date

To be completed by DHHS:

\_\_\_\_\_  
 Division Director's Signature/Date

\_\_\_\_\_  
 Team Leader's Signature/Date