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:

Physician Name	
Pediatric Specialty:	
Address:	
Telephone:	
Fax:	
Email:	

Section II: Attestation Statement

"Beginning February 1, 2006, the monies appropriated for pediatric physician sub-specialists shall only be available to a physician who: **A)** in his/her medical practice, has at least 85% of their patients who are children 18 years or younger and **B)** practices in the following sub-specialties; Adolescent Medicine, Allergy, Cardiology, Cardiothoracic Surgery, Critical Care, Developmental-Behavioral Pediatrics, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Neonatology, Nephrology, Neurology, Neurological Surgery, Ophthalmology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Radiology, Rheumatology, Surgery, Urology, and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human 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 in the pediatric specialty noted in Section I above.
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 specialists eligible for enhanced reimbursement for selected 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 S.C. Medicaid ID# (if enrolled) Date

To be completed by DHHS:

_____ _____
Division Director's Signature/Date Team Leader's Signature/Date