HIV/AIDS Specialist Form

The Department of Managed Health Care (DMHC) requires standing referrals to HIV/AIDS Specialists for patients who need continued care for their HIV/AIDS. DHMC defines an HIV/AIDS Specialist under California Code of Regulations Section 1374.16 of the Act.

In order to comply the state's regulations, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS Specialist. This information will be used for internal referral procedures and publication listing in the Provider Directory. Please ***review* and *check*** the appropriate box below.

☐ **No, thank you, I do not wish to be designated as an HIV/AIDS specialist.**

Yes, I do wish to be designated an HIV specialist and meet the following criteria:

☐ I am a member of the American Academy of HIV Medicine.

OR

☐ I am board certified or have earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of the organization establish a board certification, or a Certificate of Added Qualification, in the field of HIV Medicine

OR

☐ I am board-certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV Medicine, 5 hours of which must be related to anti- retroviral therapy;

OR

☐ In the past 24 months, I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification or recertification in Infectious Disease from a member board of the American Board of Medical Specialties;

OR

☐ In the past 24 months, I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR

☐ In the past 24 months, I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I hereby affirm that the information submitted on this form is true and correct to the best of my knowledge and is furnished in good faith.

Practitioner Printed Name:____

Practitioner Signature: ____________________________ Date: ______________