



## Telemedicine Program Provider Addendum

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### Originating Site Provider Information

Please provide a page for each originating site that is part of your telemedicine service delivery model

#### Organization Name:

NPI:

MA #:

Tax ID#:

Name of Primary Contact Person:

Title of Primary Contact Person:

Primary Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

#### Provider Type (check all that apply):

Physician (please specify type)

Nurse Practitioner

Nurse Midwife

#### Facility Type (check one):

FQHC

Local Health Department

Hospital, including emergency department

Nursing Facility

Renal Dialysis Center

Private Office

#### Originating Site

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

Distant site provider information follows on page 2.

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**Distant Site Provider Information**

Please provide a page for each distant site that is part of your telemedicine service delivery model

**Organization Name:**

NPI:

MA #:

Tax ID#:

Name of Primary Contact Person:

Title of Primary Contact Person:

Primary Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

**Provider Type (check all that apply):**

Physician (please specify type)

Nurse Practitioner

Nurse Midwife

**Facility Type (check one):**

FQHC

Local Health Department

Hospital, including emergency department

Nursing Facility

Renal Dialysis Center

Private Office

**Distant Site**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

**Please attach a copy of the contract or agreement between the Originating Site and the Distant Site provider, including billing-related responsibilities for each provider.**

Telemedicine service delivery plan details follow on page 3.

## **Telemedicine Service Delivery Plan**

**Please provide and attach information for the following areas.**

1. How many individuals do you expect to serve through telemedicine?
2. Describe the telemedicine needs assessment conducted and attach any relevant documentation. If no needs assessment has been conducted, address what gaps in coverage exist that would justify telemedicine use.
3. Describe services to be provided.
4. Describe protocol for determining medical necessity for Originating Site providers.
5. Describe protocol for confidentiality.
6. Describe procedures for maintenance of telemedicine documentation in the individual's medical record at both the Originating Site and Distant Site.
7. Describe pharmacy protocol, as it relates to telemedicine.
8. Describe the quality monitoring system for telemedicine care.
9. Describe the plan to evaluate the success of your telemedicine program.
10. Describe technology you will use to perform telemedicine services. Please provide specific names or technology or software.
11. Provide a written contingency plan for when telemedicine is unavailable.
12. Please provide any additional information you think would be helpful.
13. Please attest that all participating originating and distant sites have, at a minimum, video technology components as follows:
  - A camera that has the ability to manually or under remote control provide multiple view of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation;
  - Display monitor size sufficient to support diagnostic needs used in the telemedicine service;
  - Audio equipment that ensures clear communication and includes echo cancellation;

- Bandwidth speeds sufficient to provide quality video to meet or exceed 15 frames per second; and
- Creates video and audio transmission with less than 300 milliseconds.

## **ATTESTATION REQUIRED ON FOLLOWING PAGE**

**I attest that all participating sites meet the minimum technology requirements listed above and will continue to meet the requirements as long as telemedicine services are being provided.**

Addendum submission information is on the following page.

**Provider addendum may be submitted for review via email, fax, or mail.**

**Email:** [dhmh.telemedicineinfo@maryland.gov](mailto:dhmh.telemedicineinfo@maryland.gov)

**Mail:** Medicaid Office of Health Services  
Department of Health & Mental Hygiene  
201 West Preston Street, Room 118  
Baltimore, MD 21201

**Fax:** 410-333-5154

**For DHMH use only**

**Internal Checklist**

Originating site:

Distant site:

NPI:

NPI:

MA #:

MA #:

Reviewer:

Approved / Denied:

Date:

Notification date regarding application status:

If applicable, date of PIS for COS change to PT 57 or 61: