AMIDA CARE
ABOVE AND BEYOND FOR YOU

TRANSGENDER ATTESTATION FORM

This form may be completed by a Physician, Nurse Practitioner, or Physician Assistant who can to attest the transgender status of a new member. To verify by submitting documentation, please use the *Transgender Verification Form.*

Applicant Information

Name on Medicaid Card: _____

Preferred Name (if different):_____

DOB: _____ Medicaid #: _____

HIV Status *(Please include most current labs)*: ☐ Positive ☐ Negative ☐ Unknown

Provider Attestation

1. Please indicate type of qualifying provider completing this form:

   ☐ Physician ☐ Nurse Practitioner ☐ Physician Assistant

2. I attest that _____ is transgender and has
   (applicant name)
   undergone appropriate clinical treatment for a person diagnosed with gender dysphoria.

Completed by:

_____ _____
Provider Name **Site Name**

_____ _____
Signature **NPI#**

_____
Date

Fax completed form to:
Transgender Health Services
Attention: Al Rubenstein
Fax: 646-786-1802
Tel: 646-757-7688