



TGNB (TRANSGENDER and NONBINARY) ATTESTATION FORM

This form may be completed by a Physician, Nurse Practitioner, or Physician Assistant who can attest to the transgender status of a new member. Per NY State Medicaid regulations for Special Needs Plans, Amida Care members must be verified within their first 90 days as transgender, unhoused, or living with HIV. Timely completion of this attestation is crucial for this member’s continued coverage with Amida Care. Homeless and HIV attestations can be found on the Amida Care website.

Applicant Information

Name on Medicaid Card: _____

Chosen Name (if different): _____

Gender Identity: _____ Pronoun(s): _____

DOB: _____ Medicaid #: _____

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

Provider Attestation

- Please indicate type of qualifying provider completing this form:
 Physician Nurse Practitioner Physician Assistant
- I attest that _____ is transgender or non- binary and has
(applicant name)
 undergone appropriate clinical treatment for a person diagnosed with gender dysphoria.
- In order to provide linkage to medically appropriate preventative health services we ask that you provide us with the member’s sex assigned at birth, as indicated below:
 Male Female Intersex Other _____

Completed by:

Provider Name

Site Name

Signature

NPI#

Date

Fax or email completed form to:
Transgender Health Services
Attention: GIST
Email: GIST@Amidacareny.org
Fax: 646-786-1802
Tel: 646-757-7982