Provider Attestation Statement
Allergy Immunotherapy (Allergy Shot Administration ONLY) for Non-Allergists

Physician's Name:	
Provider Type:	
NPI Number:	
Tax ID Number:	
Physical Address:	
Contact Number:	

Please check the following attestation statement:

- ☐ I attest that I understand allergy clinical practice guidelines recommend that I have the following equipment and staff to safely provide immunotherapy (allergy shots) to patients at my location of practice:
  - ☐ Aeroallergen and venom extract storage (4 degrees C refrigerator with alarm)
  - ☐ 1 ml (for AIT) and 3 ml (for VIT) disposable (safety) syringes with 27 gauge 5/8 inch needles
  - ☐ Epi-pen auto injectors – 0.3 mg for adults and 0.15 mg for children
  - ☐ Crash cart – BLS+ level
  - ☐ Glucagon
  - ☐ Vital Signs monitor
  - ☐ Oxygen administration equipment
  - ☐ Personnel with BLS+ training
  - ☐ Personnel trained to give shots, recognize and treat anaphylaxis

Physician Signature:		Date:	
Printed Name:			

By signing this document, I certify that the information provided herein is true, accurate and complete to the best of my knowledge. I understand that under my Provider Participation Agreement, Superior HealthPlan, and applicable Regulators including the Centers for Medicare and Medicaid Services, and the Texas Health & Human Services Commission or their Representatives, may inspect and evaluate my records related to Members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and Federal and State Laws or Regulations.