



HEALTH CARE  
AUTHORITY

**Michelle Lujan Grisham, Governor**  
Kari Armijo, Secretary  
Alanna Dancis, Acting Medicaid Director

## New Mexico EVV System Declaration Form

This form is to be completed and signed by agencies. This will enable us to identify whether you will be using the State/MCO-sponsored EVV solution, AuthentiCare, or using a Third-Party EVV solution. If you use a Third-Party EVV solution it must be approved by Conduent on behalf of New Mexico Health Care Authority or Turquoise Care MCOs.

Please submit the completed form, along with any questions you may have, to:

[ConduentEVVaggregatorsupport@conduent.com](mailto:ConduentEVVaggregatorsupport@conduent.com) Please

fill in your agency/provider information:

|                      |  |
|----------------------|--|
| Name                 |  |
| Medicaid Provider ID |  |
| Contact Person Name  |  |
| Contact Person Phone |  |
| Contact Person Email |  |
| Mailing Address 1    |  |
| Mailing Address 2    |  |
| City                 |  |
| State & Zip Code     |  |

**New Mexico Health Care Authority**

Office of the Secretary | PO Box 2348 - Santa Fe, NM 87504 | Phone: (505) 827-7750 Fax: (505) 827-6286



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Please fill in your EVV solution vendor selection and information:

- I will be using the State Sponsored EVV Solution, NM AuthentiCare.
- I will be using a Third Party EVV solution and will complete the box below for:
  - MCO**
  - FFS**
  - Both (MCO and FFS)**

|                             |  |
|-----------------------------|--|
| Name of Vendor/Company      |  |
| Name of EVV solution        |  |
| Vendor Contact Person Name  |  |
| Vendor Contact Person Phone |  |
| Vendor Contact Person Email |  |

I agree that the information I have provided is accurate and that I will comply with the State of New Mexico EVV requirements.

Name: \_\_\_\_\_ Email: \_\_\_\_\_

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

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