ATTESTATION REGARDING COMPLIANCE WITH THE PRACTICE OF CONCIERGE MEDICINE BY PRIMARY CARE PROVIDERS POLICY ("POLICY")

Your practice has notified the Plan (as defined in the Policy) that some or all of your physicians engage in concierge medicine. Per the Plan's Policy, you must complete and return this attestation as part of the credentialing/recredentialing process or, if requested outside of that process, within 30 days of your receipt of this form. **Failure to return a signed copy of this attestation within this required timeframe may result in your termination from the provider networks of the Plan.**

Please check the box and sign below to indicate your practice is attesting to the statement.

☐ ATTESTATION TO COMPLIANCE WITH THE PLAN'S POLICY AND APPLICABLE LAW: My practice's concierge medicine program complies with: (1) the requirements of the Plan's policy on concierge medicine, and (2) all applicable state and federal law on concierge medicine.

I, the undersigned, as a physician in the provider group listed below, hereby attest to the truth and accuracy of the checked statement above.

By: _____

Physician Name: _____

NPI: _____

TIN: _____

Date: ____/____/____

Provider Group (if applicable): _____

NPI: _____

TIN: _____