Kansas City
P.O. Box 419169, Kansas City, MO 64141-6169 | 816-395-2222 | BlueKC.com

Collaborating Physician Attestation

I, [Collaborating Physician], certify that I am a physician licensed to practice medicine in [State] and that I am contracted with Blue Cross and Blue Shield of Kansas City (Blue KC) to provide services in one or more of Blue KC's networks as fully set forth in the Network Agreement dated [Date] ("Network Agreement").

I further certify I have entered into a Collaborative Practice Agreement in accordance with the applicable state's laws with [NAME] who is an Advanced Practice Provider ("APP") licensed in [State]. The APP will provide the delivery of health care services to individuals covered under a plan of benefits provided by or administered by Blue KC pursuant to the terms of the Network Agreement.

If, after submitting this attestation, any changes occur that affect the accuracy of any information provided in this attestation, I agree that I will promptly, and in no event longer than thirty (30) days of the date I became aware of the change, contact Blue KC to update the information in this Attestation.

I agree to cooperate with Blue KC as may be appropriate and necessary to verify the information contained in this attestation.

By signing my name and the date below, I certify to the accuracy and completeness of all information provided in this Collaborating Physician Attestation.

Dated: [DATE]

[CITY], [STATE]

_____

[COLLABORATING PHYSICIAN SIGNATURE]

_____

[PRINTED NAME]