Attachment B: PCMH Program Attestation

This will acknowledge that the following Primary Care Physician(s) (PCPs) and Certified Registered Nurse Practitioner(s) (CRNPs) have agreed to participate in the CareFirst Patient-Centered Medical Home Program (PCMH) described in the contract addendum to the Master Practice Participation Agreement.

Each undersigned provider is practicing with the practice and, by signing this attestation, enrolls and agrees to participate in the PCMH Program described in the contract addendum to the Master Participation Agreement and to comply with the rules and requirements set out in the PCMH Description and Guidelines.

Note: All PCPs and CRNPs within the practice must agree to participate in the PCMH Program.

PARTICIPANT INFORMATION	
PCP/CRNP Printed Name:	Primary Specialty:
PCP/CRNP Signature and Date (Required):	Active CAQH Number:
Regional Provider and Member Number:	PCP/CRNP National Provider ID (Rendering Practitioner Identifier – Type I):
Do you agree to have an Open BlueChoice Panel? ◯ Y ◯ N	If NO, is your panel closed to all other Payors? ◯ Y ◯ N

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PCP/CRNP Printed Name:	Primary Specialty:
PCP/CRNP Signature and Date (Required):	Active CAQH Number:
Regional Provider and Member Number:	PCP/CRNP National Provider ID (Rendering Practitioner Identifier – Type I):
Do you agree to have an Open BlueChoice Panel? ◯ Y ◯ N	If NO, is your panel closed to all other Payors? ◯ Y ◯ N

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Do you agree to have an Open BlueChoice Panel? ◯ Y ◯ N	If NO, is your panel closed to all other Payors? ◯ Y ◯ N

PARTICIPANT INFORMATION	
PCP/CRNP Printed Name:	Primary Specialty:
PCP/CRNP Signature and Date (Required):	Active CAQH Number:
Regional Provider and Member Number:	PCP/CRNP National Provider ID (Rendering Practitioner Identifier – Type I):
Do you agree to have an Open BlueChoice Panel? ◯ Y ◯ N	If NO, is your panel closed to all other Payors? ◯ Y ◯ N

Note: If more space is needed to list additional participants, please make a copy of this form.