PCMH
Patient-Centered Medical Home

CareFirst
From the CareFirst BlueCross BlueShield family of health care plans.

Attachment B: PCMH Program Attestation

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

Each undersigned Practitioner is practicing with the Practice and by signing this Attestation, enrolls and agrees to participate in the PCMH Program described in the Addendum to the Master Practice Participation Agreement and to comply with the rules and requirements set out in the Patient-Centered Medical Home Description and Guidelines.

Note: All Primary Care Physician(s) and Certified Nurse Practitioner(s) within the Practice must agree to participate in the Patient-Centered Medical Home 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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(CONTINUED ON REVERSE)

Attachment B: PCMH Program Attestation (cont'd)

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