BlueCross BlueShield of Western New York

BlueCross BlueShield of Western New York
Nurse Practitioner
Agreement/Acknowledgement

I attest that I abide by New York State regulations and BlueCross BlueShield of Western New York ("BlueCross BlueShield") policy and procedure in that I have an agreement between my collaborating physician and myself that clearly delineates the scope of my practice.

I have been provided relevant portions of the BlueCross BlueShield Participating Physician Agreement for the collaborating physician referenced below or the Participating Medical Group Agreement under which he/she is participating with BlueCross BlueShield (the "Participation Agreement") and copies of the relevant portions of the Provider Manual (the "Provider Manual"). I agree to adhere to and be bound by the terms of such Participation Agreement and Provider Manual.

I understand that, unless I have an affiliation with a new collaborating physician who is participating with BlueCross BlueShield and have so updated BlueCross BlueShield, in the event that I no longer am employed by or affiliated with the Physician/Medical Group identified above, that I will no longer be considered participating with BlueCross BlueShield as of the date of cessation of employment of affiliation with Physician/Medical Group.

Printed name of nurse practitioner	NPI
Signature of nurse practitioner	Date signed

I hereby acknowledge that I am the collaborating physician for the nurse practitioner listed above and agree to be the cosigning physician and that the services performed by the above nurse practitioner are attributable to my utilization report. I further agree to cooperate with BlueCross BlueShield in all quality management and utilization review activities pertaining to the services of the mid-level practitioner.

Printed name of collaborating/sponsoring physician	NPI
Signature of collaborating/sponsoring physician	Date signed