BlueCross BlueShield of Illinois

Corporate Credentialing, 23rd Floor
300 E. Randolph St.
Chicago, Illinois 60601-5099

To Practitioners applying for Participation with HMO, PPO and Point of Service product:
Submit this attestation, signed & dated, along with State of Illinois Health Care Professional Credentialing/ Recredentialing and Business Data Gathering Form.

ATTESTATION FOR PROVIDER CREDENTIALING

I authorize **Blue Cross and Blue Shield of Illinois (BCBSIL)** to consult with hospital administrators, members of hospital medical staffs, professional liability carriers, managed care organizations, the National Practitioner Data Bank, and other persons or entities to obtain information concerning my qualifications, including, but not limited to, my professional qualifications, background, abilities, competence and my practice history.

I consent to the release to BCBSIL of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I authorize BCBSIL to release this information, as well as quality assurance data relating to me, to medical groups, independent practice associations and similar entities contracting with BCBSIL and as authorized under state and federal law or regulation.

I release BCBSIL and any and all persons or entities providing information about me to BCBSIL from any and all liability connected with or arising from the release of such information, provided that such party(ies) was acting in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I have the burden of providing adequate information to BCBSIL to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care networks contracting with BCBSIL.

If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify BCBSIL or the appropriate subsidiary or affiliate within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care networks contracting with BCBSIL.

I agree that a photocopy of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original.

I attest that the information contained in this application is correct and complete.

Physician Signature _____ **Date** _____

Physician Name (Please Print) _____ **License Number** _____