HOSPITAL COVERAGE LETTER

To: Blue Cross and Blue Shield of Illinois (BCBSIL)

Date: ________________________________

Please accept this correspondence as confirmation that since I do not have active admitting privileges at a participating network hospital (in the applicable BCBSIL provider network(s) in which I participate), with the exception of medical emergencies, my practice will be confined to outpatient care.

I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer BCBSIL subscriber/member care to a participating physician or hospitalist (in the applicable BCBSIL provider network) who has active admitting privileges at a participating network hospital (in the applicable BCBSIL provider network).

(Please print legibly)

Provider’s Name: _______________________________________________

Provider’s NPI #: _______________________________________________

Provider’s Signature: ____________________________________________

BCBSIL provider networks include: 1) HMO Illinois, 2) Blue Advantage HMO, 3) Blue Precision HMO, 4) Blue Medicare Advantage HMO 5) Medicare Medicaid Alignment Initiative 6) BlueChoice PPO, 7) Blue Medicare Advantage PPO.

Note: If you are unsure of the participation status in a specific BCBSIL provider network, for yourself, another physician, hospitalist, or hospital, please contact your local BCBSIL Provider Relations office by fax or phone.

<table>
<thead>
<tr>
<th>Provider Relations Office</th>
<th>FAX Number</th>
<th>Telephone Number</th>
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<tbody>
<tr>
<td>Illinois</td>
<td>312-540-8609</td>
<td>312-653-6555</td>
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