GROUP PROVIDER CERTIFICATION

I certify that I am providing services under Tax ID # _____ and agree to comply with the terms of the group provider agreement as signed by the appointed group representative.

I have agreed to participate in the following:

Medicare

☐ Capitation

☐ Fee for Service

Medicaid/Essential Plan/CHP

☐ Capitation

☐ Fee for Service

Provider Signature **Date**

Printed Name

Network Solutions IPA

IPA Name