blue CALIFORNIA | PROMISE

Unsatisfactory Immigration Status Data
PROVIDER ATTESTATION

I, _____, do hereby attest as follows:

1. I am authorized on behalf of

   _____

   (legal name of provider organization, medical group, practice, facility, or other contracted provider entity) ("Provider") to provide this attestation to BSCPHP.

2. The Provider is presently contracted with Blue Shield of California Promise Health Plan ("BSCPHP") to provide medical services to BSCPHP members, some of whom may have unsatisfactory immigration status ("UIS").

3. As a provider of medical services to BSCPHP members, the Provider seeks access to UIS data for members assigned to the Provider. The Provider understands and agrees that it may use this data only for care coordination and care management purposes, and to meet deliverable requests made by BSCPHP on behalf of the Department of Health Care Services ("DHCS"). The Provider agrees to treat this data as protected health information ("PHI") in accordance with all applicable privacy laws and regulations.

I certify under penalty of perjury under the laws of the State of California that, to the best of my knowledge, information, and belief, and to the extent indicated or limited above, the statements contained in this attestation are true and correct.

_____ Authorized Representative Signature

_____ Date

_____ Printed Name

_____ Title

_____ Provider Organization Legal Name

_____ Provider NPI or TIN, if applicable

_____ City

_____ State

_____ Email Address

_____ Telephone Number

Please send your completed attestation by SECURE email to HR1@blueshieldca.com.

blueshieldca.com/promise