Provider Attestation for Abortion Services

Find this form online at **provider.bcbst.com/tools-resources/documents-forms**. You can find the PWK Fax Coversheet by **clicking here**.

Date of Service: _____/_____/20 ______

Member Name: ______________________________ Phone: ______________________

Member ID Number: ______________________________ Date of Birth:______/______/ ___________

Street Address:____

City: ______________________________ State: ______ ZIP: _________________

Based on my professional judgment, I certify that the services to be provided to the individual listed above are provided in compliance with any and all applicable state and federal laws regarding abortion to which the member, provider, and/or the services provided may be subject.

Physician Performing Abortion

Provider Name:______________________________ NPI #: ______________________

Street Address: ______________________________ State: ______ ZIP: _________________

Physician Signature (Required) : ____

(By signing, the provider confirms the above information is accurate and verifiable by patient records.)

Date:_____ / ______/ ____________

Fax the completed form and clinical information to **(423) 591-9481**.
If you have questions, please call Provider Service at **1-800-924-7141**.

BlueCare Tennessee and BlueCross BlueShield of Tennessee, Inc., Independent Licensees of the Blue Cross Blue Shield Association.

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