Name of Provider: ______________________________________

ACKNOWLEDGEMENT OF BLUE SHIELD PROMISE HEALTH PLAN
PROVIDER MANUAL

The Provider Manual is intended to be used as a guideline for the provision of Covered Health Care Services to Plan Members. This Manual contains policy, procedures, and general reference information on Blue Shield Promise Quality Management, Utilization Management and Encounter Reporting, Health Education, Member and Provider Grievances, and other administrative issues including standards of care to be provided to plan members.

By signing below, you are acknowledging that you have been instructed on the provider manual. You may also view the provider manual via the Blue Shield Promise website, www.blueshieldca.com/promise.

______________________________________ __________________

Signature/ Medical Group Name Date

By:

Name ________________________________

Title ________________________________

Return completed Acknowledgment of Blue Shield Promise Health Plan Provider Manual form to:
Fax: (323) 889-5418 or
Email: ProviderRelations@blueshieldca.com