ATTACHMENT B
PROVIDER PARTICIPATION ATTESTATION

WHEREAS, MHS Health Wisconsin, has executed an Agreement with _____ ("Group") (***insert name of contracting Group***) dated ***(date to be completed by MHS Health Wisconsin)*** pursuant to which Group has agreed to provide Covered Services to Cenpatico Covered Persons through Group Clinicians (the "Agreement"); and

WHEREAS, Group has requested that the undersigned provider ("Provider") serve as a Group Clinician under the Agreement and Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Group Clinician" under this Agreement, Provider must satisfy MHS Health Wisconsin's credentialing and recredentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement and any Attachment thereto.
NOW THEREFORE, Provider hereby agrees as follows:

1. Provider agrees to provide Covered Services to Covered Persons in accordance with the requirements of the Agreement and any Attachment thereto so long as Provider qualifies as a Group Clinician.

2. Provider understands and agrees that his/her initial and continued participation as a Group Clinician under the Agreement and any Attachment thereto is contingent upon meeting and complying with MHS Health Wisconsin's credentialing and recredentialing standards and otherwise complying with the terms and conditions of the Agreement.

3. Provider acknowledges that MHS Health Wisconsin expressly reserves the right to reject, suspend, and/or terminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply with the term of the Agreement or any Attachment thereto; (ii) meet MHS Health Wisconsin's credentialing and recredentialing requirements; or (iii) comply with the Provider Manual.

4. Provider shall be effective as of _____ ***(to be completed by MHS Health Wisconsin).***

Provider Name (print):_____

Provider Signature: _____

Signature Date: _____

License Type: _____ NPI Number:_____

State Medicaid Number:_____ Medicare Number:_____