***HealthCare Partners, IPA*.**

Please review, fill out the information requested on the signature page, sign the signature page, and return this entire document by fax to HealthCare Partners, IPA. at ***516-294-9470***

"Opt In" Statement and Signature Page

"By signing _____ fully understands and acknowledges that the Empire BlueCross BlueShield/HealthCare Partners IPA, Inc. Agreement will supersede any other Agreement that _____ may have previously entered into with Empire BlueCross BlueShield.

It is further understood and acknowledged that any physician opting into this agreement, under the TIN(s) indicated below, will be reimbursed according to the terms of the HealthCare Partner IPA, Inc Agreement. If you are designated as a Primary Care Provider, by signing below, you will be enrolled into the Enhanced Personal Health Care program through the HealthCare Partners IPA, Inc., and cannot be enrolled into any other risk arrangements that may have previously entered into with Empire BlueCross BlueShield and/or any other networks of physicians who are collaborating together for a risk arrangement."

PROVIDER LEGAL NAME **_____**

By: _____ _____
Signature Authorized Representative of Provider(s) Date

Printed: _____ _____
Name Title

Address: _____ _____
Street City State Zip

(Note: If any of the following is not applicable, please leave blank)

License#: _____

NPI: _____

TIN (s) _____

Facsimile No: _____

Email Address: _____

Web Site: _____

Medicare#: _____