*Attestation of Provider Directory Accuracy*

In compliance with applicable state and federal laws, our organization has verified provider and demographic information for accuracy. The attached spreadsheet contains a complete listing of providers and locations associated with (insert name of DSO or large group), which can be utilized to update (insert name of health plan’s) directory of participating providers and locations.

Name of person attesting to data accuracy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date information verified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosure of provider email address:

\_\_\_\_\_ The email address may be displayed in the Provider Directory

\_\_\_\_\_ The email address is intended for patient communication

\_\_\_\_\_ The email address is regularly monitored, and is maintained in a manner consistent with state and federal health privacy laws.

*All three disclosures must be checked for the email address(es) to be displayed in the Provider Directory.*

*I represent and warrant that I am authorized to verify, request and submit changes for the practice*

*information displayed in the attached spreadsheet. I also represent and warrant that the attached information is true and complete to the best of my knowledge.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date