

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 par	tient 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 .			

BlueCross BlueShield of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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