of Tennessee

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 patient 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**.

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