PARTICIPATING PROVIDER AGREEMENT WITH HIGHMARK BLUE SHIELD

(AGRPBS)

Under the applicable laws of the Commonwealth of Pennsylvania, I am duly authorized to engage in the practice of _____. In consideration of being registered by Highmark Inc. d/b/a Highmark Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association (hereinafter termed "Blue Shield"), as a participating provider, I do hereby agree as follows:

I will perform services for Blue Shield members, make reports to Blue Shield concerning such services and accept compensation therefore, as provided for in the Blue Shield Regulatory Act, as heretofore or hereafter reenacted or amended, and the Bylaws, the applicable Regulations, the applicable Subscription Agreements and Master Contracts, all as heretofore or hereafter adopted or entered into by Blue Shield under authority of said Regulatory Act, with any required governmental approval.

Copies of the Blue Shield Regulatory Act, and the Bylaws, Regulations, Subscription Agreements and Master Contracts referred to in this Agreement shall be available for examination by me during regular business hours at the principal office of Blue Shield. A copy of the Regulations shall be provided to me upon execution of this Agreement and thereafter upon my request.

I understand that this Agreement constitutes a contract between Blue Shield and me, that Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Blue Shield to use the service mark in the Commonwealth of Pennsylvania, and that Blue Shield is not contracting as the agent of the Association. I further understand and agree that I have not entered into this Agreement based upon representations by any person other than Blue Shield and that no person, entity or organization other than Blue Shield shall be held accountable or liable to me for any of Blue Shield's obligations created under this Agreement.

This Agreement shall continue in effect until terminated by me giving thirty (30) days prior written notice to Blue Shield, unless the Regulations provide otherwise; or until terminated by Blue Shield with the approval of the Pennsylvania Department of Health.

Signed

Name - *Please print*

Date

Specialty

Social Security number

National Provider Identifier (NPI)

Pennsylvania license number**

Attach a copy of your current Pennsylvania license.

Accepted by

Date

Highmark Blue Shield provider number

Mail To: PROVIDER DATA SERVICES
POST OFFICE BOX 898842
CAMP HILL, PA 17089-8842

Main practice address* (primary physical practice location)

Street

City State ZIP code

( )
Telephone number

Mailing address (if different from above)*(where administrative work is done)

Street

City State ZIP code

Previous main practice address (if at current address less than two years)

Street

City State ZIP code

Check address* (address to which checks are sent)

Street

City State ZIP code

Is this a lockbox? ❑ Yes ❑ No

* YOUR PROVIDER RECORD WILL BE UPDATED BASED ON THE INFORMATION REPORTED ON THIS AGREEMENT.

 ** ACTIVE PENNSYLVANIA LICENSE IS REQUIRED TO BECOME PARTICIPATING.