Please send the completed form to:
Fax: 1-508-368-9902
Attn: Provider Relations Coordinator

# Attestation for OB/GYN Provider Status for Fallon 365 Care, Wellforce Care Plan and Berkshire Fallon Health Collaborative

Fallon Health requires that all obstetrician/gynecologists (OB/GYNs) complete this attestation for our MassHealth Accountable Care Organizations (ACOs). Please note that for all other Fallon products, OB/GYNs are only identified as specialty care providers.

Please complete the appropriate section below that reflects your desired participation status with Fallon for Fallon MassHealth ACOs. If requesting a primary care designation, please take time to consider the increased demands of functioning in the primary care role. **All OB/GYNs must sign at the bottom of the form, regardless of the provider status you choose.**

If you wish to change your status in the future, you can request a blank attestation from Provider Relations and resubmit a completed form. Fallon will process any change in practice status within 60 calendar days of receipt of a newly completed form.

## Complete if you wish to act soley as a specialty care provider:

I, _____, certify that I will be practicing as a non-primary care provider. I will not hold a panel of members. I do not plan to offer routine primary care in addition to specialty obstetric/gynecologic care. I wish to be listed as a specialist only in all Fallon Health directories.

**Complete if applicable:** I certify that I am affiliated with _____ Provider Organization.

## Complete if you wish to act as both a specialty and primary care provider:

I, _____, certify that I intend to practice both as an obstetrician/gynecologist and as a primary care provider. I wish to be listed as both a primary care and specialty care physician in the Fallon Health MassHealth ACO directories. I will hold a panel of members. I will be available for all primary care for female members of my panel. My panel status is (check one):

_____ Open _____ Closed _____ Limited (Describe limitations below.)

Description of limitations: _____

**Complete if applicable:** I certify that I am affiliated with _____ Provider Organization.

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Signature: _____ Date: _____