Providence
Health Plan

AMBULATORY SURGERY CENTER ACCESS: PHYSICIAN ATTESTATION

Name: _____

Tax ID/NPI: _____

On this ____ day of _____, 20____ I attest that I am unable to use an ambulatory surgery center (ASC) to provide patient care due to at least one of the following:

☐ There is no geographically accessible ASC (within 25 miles); **or**

☐ There is no geographically accessible ASC (within 25 miles) at which I, the physician, have privileges to perform the procedure(s).

I declare that the above statement is true and accurate and that I will make reasonable efforts to update the attestation on file with The Plan if any of the above statements change.

_____

Physician Signature

Please return this form via email to PHPMedicalPolicyInquiry@providence.org

Disclaimer: This attestation does not constitute medical advice nor a guarantee of coverage. Payment is based on eligibility and benefits at the time of service. This attestation will be reviewed at least annually and may be updated or rescinded at any time by The Plan or The Provider. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Plan Medical Policy will be resolved in favor of the coverage agreement.