



# Thurston County Project Access

Respect, Advocacy, and Responsibility



## PROVIDER PLEDGE FORM

Provider Name:					
Group/Practice Name:					
Specialty:					
Mailing Address:					
	City:		State:		Zip:
Contact Person:					
Phone:					
Fax:					
Email:					
Participation Pledge:	<input type="checkbox"/> I will accept up to _____ new Project Access referral(s) per month. I agree to assess and treat patient's free-or-charge for an initial period of up to six months. I understand that TCPA may extend coverage for uninsured or underinsured patients who continue to need follow-up care. My practice will submit charges to Project Access for reporting purposes only.				
Acceptable Insurance:	My practice accepts the following health care insurance plan(s): <input type="checkbox"/> BHP – CHPW <input type="checkbox"/> BHP – Group Health <input type="checkbox"/> BHP - Molina <input type="checkbox"/> Medicaid				
Are there any medical conditions addressed by your specialty that TCPA should not refer to you?	Please list conditions not accepted (continue on back of form if needed):				
<input type="checkbox"/>	Please contact me. I have additional questions regarding my role in Project Access.				
Recommend TCPA	I recommend the following colleague as a potential Project Access participant:				
	Name:	Specialty:		Phone:	
Signature:				Date:	

Please fax this completed form to 360-493-7708 or by mail to Project Access

**THANK YOU.**