WORLD TRADE CENTER NATIONWIDE PROVIDER NETWORK

Provider Attestation

Thank you for your continued participation in the World Trade Center (WTC) Nationwide Provider Network, (NPN). Currently, you are recognized as a participating provider in the Sedgwick network. Your responses to the questions below will ensure continued participation in the WTC NPN and uninterrupted care to the WTC Health Program member.

Please check on the of the following options, indicating your status:

☐ I agree to continue to participate in the World Trade Center Nationwide Provider Network. By selection this option I understand and accept the terms and conditions of participation with the World Trade Center Health Program Nationwide Provider Network.

☐ I have retired from practice, no longer treating WTC Health Program members, or wish to discontinue participation from the WTC NPN. (Please skip to signature line below)

For Continued Participation Please provide the following:

The following locations are associated with Tax ID#: _____

Group/Facility NPI: _____

Individual Provider NPI: _____

Treating office location:

Location Name: _____ Phone: 1- _____

Address 1: _____

Address 2: _____

City, State, Zip: _____ _____ _____

Additional Treating office locations:

Location Name: _____ Phone: 1- _____

Address 1: _____

Address 2: _____

City, State, Zip: _____ _____ _____

Provider Specialties:

The specialty(s) categories listed below will be represented in the Provider Search Tool used to by other WTC providers, program nurse case managers, members, and the public.

_____ _____

_____ _____

_____ _____

Provider Certification:

I certify that the information on this form is true and correct. I understand that misrepresentation may result in removal from the World Trade Center Nationwide Provider Network as a participating provider. I understand that this form does not entitle me to participation in any Sedgwick Network, owned and operated by Sedgwick and/or subsidiaries (collectively "Sedgwick") and that I must meet certain criteria prior /and continued to my status as a participating provider. I authorize the copy of my signature on this form to be as bind as the original. I agree that Sedgwick, its representatives, and any individuals or entities providing information to Sedgwick in good faith shall not be liable for any act or omission related to the evaluation or verification contained on this form. I further agree to notify Sedgwick in a timely manner of any change in the information

requested in this form. Failure to update my information may result in removal as a network provider. I will retain a copy of this authorization for my own purposes.

I will continue to participate in the World Trade Center Nationwide Provider Network and will notify the WTC NPN promptly if my status as a participating provider should change. I agree to the Terms and Conditions set forth by the World Trade Center Health Program inclusive of treatment guidelines and billing requirements administered by the WTC NPN.

Continued Treatment of WTC Health Program Members and associated billing submitted to the World Trade Center Nationwide Provider Network for treatment dates on or after May 1, 2022 will constitute an intent of continued participation in the Program.

A properly executed version of this document containing your actual signature, delivered by facsimile or electronic mail is as valid as an original.

Print Name: _____ Date: _____

Electronic Signature: _____ Date: _____

Email: _____