NORTH CAROLINA STATE HEALTH PLAN
NETWORK PARTICIPATION AGREEMENT

PROVIDER SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned party has caused its duly authorized representative to sign and acknowledge its agreement to the terms of the North Carolina State Health Plan Network Participation Agreement,* which will become effective in accordance with the foregoing terms. You further agree that your submission of this signature page to Blue Cross NC also constitutes written notice to Blue Cross NC of updated notice address under provider's separate contract with Blue Cross NC for commercial (under 65) lines of business.

Provider Legal Name: By (Signature): Print Name: Title: Date:	Federal Tax Identification Number(s) (TIN): Type 2 Outbound (Payment) National Provider Identifier(s) (NPI):
Contract Contact Name: Contractual Notice Address: Notice Email Address: Notice Contact Phone Number:	

* The full terms of the North Carolina State Health Plan Network Participation Agreement can be accessed at www.bluecrossnc.com/providers/ncstatehealthplannetwork. In the event that the Agreement is removed from this location, a copy of the terms will be supplied to you using the contact information above.

NORTH CAROLINA STATE HEALTH PLAN
NETWORK PARTICIPATION AGREEMENT

BLUE CROSS NC SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned party has caused its duly authorized representative to sign and acknowledge its agreement to the terms of the North Carolina State Health Plan Network Participation Agreement, which is effective in accordance with the foregoing terms.

Blue Cross and Blue Shield of North Carolina
By: Print Name: Title: Date: