

**Attestation for Participation****Practitioner Name (print):****Practitioner No.:**

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**E-mail Address:**

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**I wish to provide the service(s) described below.** I recognize the unique definition and clinical objectives of these services and will work with each accepted referral to meet them. In return, Evernorth Behavioral Health will work to ensure each appointment is appropriately authorized and will reimburse for the services provided.

Please circle which of the following services you are interested in providing:

**CRISIS 24/7**

Crisis 24/7 practitioners will make themselves available through the use of pagers, and/or answering services to Evernorth Behavioral Health as well as their participants after hours and on weekends. Their voice mails should not routinely instruct participants to go to the nearest ER, unless determined to be medically necessary.

**CRISIS NON-24/7**

Crisis Non-24/7 practitioners will make themselves available for crisis appointments during business hours only (8:00 AM-6:00 PM).

**INTERMEDIATE CARE**

This level of intervention provides precautionary and preventive care to a participant who presents with a level of acuity that if not addressed within 48-hours, could escalate to a higher level of care.

**MEET & GREET**

This pre-discharge visit is conducted by a contracted non-MD practitioner for the purpose of coordinating and scheduling an ambulatory follow-up appointment, 2-7 days after discharge.

Practitioner Signature

Date

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Practitioner Name (Print)

E-mail Address

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Crisis Contact Number (Circle Type):

Office

Cell

Pager

Once completed, please return to:

Fax: **860.687.7257**

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