blue california
Promise Health Plan

Medical Loss Ratio P&P Attestation

Date: _____

I, _____(Print Name) attest that

_____(Organization Name)

has updated its Policies and Procedures to align with the Medical Loss Ratio Requirements as stated in the Department of Health Care Services All Plan Letter 24-018 "Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors."

Provider/Authority Signature: _____

Title: _____

Organization NPI#: _____

Return completed Attestation to ProviderSolvency@blueshieldca.com.