MetroPlusHealth

**Attestation of Collaborative Relationship**

I _____ affirm that, pursuant to New York State

(PRINT, Name of Midwife)

Education Law, I have a collaborative relationship with the following MetroPlus Health Plan (MetroPlus) participating obstetrician-gynecologist:

_____

**Name of MetroPlus Participating Obstetrician-Gynecologist**

_____

**NPI** for MetroPlus Participating Obstetrician-Gynecologist

Signature: _____

Date: _____