EXHIBIT 2
PARTICIPATING PROVIDER ATTESTATION

WHEREAS, Magnolia Health Plan, Inc., LLC ("Health Plan"), has executed an agreement with _________________________ ("Group") dated __________, pursuant to which Group has agreed to provide Covered Services to Covered Persons through Group Clinicians (the "Agreement");

WHEREAS, Group has requested that the undersigned provider ("Provider") serve as a Group Clinician under the Agreement and Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Group Clinician" under the Agreement, Provider must satisfy Health Plan's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement that are applicable to Group Clinicians, as set forth below.

NOW THEREFORE, Provider hereby agrees as follows:

1. As long as Provider qualifies and participates as a Group Clinician under the Agreement, Provider agrees to provide Covered Services to Covered Persons in accordance with the requirements of the Agreement that are applicable to Group Clinicians, which shall include the following terms: Sections 3.3 through 3.17; Article IV; Article V; Article VI; Article VII; Article VIII; Section 9.1; and Sections 10.4 through 10.7.

2. Provider understands and agrees that his/her initial and continued participation as a Group Clinician under the Agreement is contingent upon his/her meeting and complying with Health Plan's credentialing standards and otherwise complying with the terms and conditions of the Agreement.

3. Provider acknowledges that Health Plan expressly reserves the right to reject, suspend, and/or terminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply with the term of the Agreement or any Attachment thereto; and (ii) meet Health Plan's credentialing requirements.

4. This Attestation shall be effective as of ____________.

Provider Name (print):____________________________________

Provider Signature: ______________________________________
Signature Date: ___________________________
License Type: ___________________________ NPI
Number:_________________________

State Medicaid Number:____________________ Medicare Number:______________________