Must be completed if you are Health Professional

COLLABORATING PHYSICIAN STATEMENT

AS THE SUPERVISING PHYSICIAN FOR:

_____

Name of Practitioner

I CAN ATTEST THAT HE/SHE IS PROVIDING CARE FOR MANAGED HEALTH SERVICES AND NETWORK HEALTH PLAN MEMBERS SOLELY AT THIS LOCATION(S) AND NOT IN THE PATIENT'S PLACE OF RESIDENCE.

Practice Locations:

Date:

Signature of Supervising Physician

Print Supervising Physician's Name

Supervising Physician's NPI