COLLABORATING/SUPERVISING PHYSICIAN AGREEMENT

In providing care to Medicaid Health Plan members, I,

MD/DO **NPI**

Agree to collaborate/supervise with

NP/PA **NPI**

1. I confirm that I am the Collaborating/Supervising Physician for the above-named Nurse Practitioner or Physician Assistant.

2. I agree to abide by all laws, rules, and regulations, including policies and procedures governing the collaboration of Nurse Practitioners or Physician Assistants at Medicaid Health Plan(s) participating hospitals.

3. I agree to inform the Medicaid Health Plan in the event that I have concerns concerning the quality of care provided by the Collaborative Nurse Practitioner or Physician Assistant.

4. I agree to immediately notify the Medicaid Health Plan(s) in the event the scope or nature of my professional affiliation with the Collaborative Nurse Practitioner or Physician Assistant changes.

5. I agree to comply with all regulations of the State Medical Board and the Michigan Public Health Code with respect to my supervision of the Collaborative Nurse Practitioner or Physician Assistant.

Signature, Collaborating/Supervising Physician Date

*Signature must be within 12 months of submission