Collaborating Clinician Statement

As the Collaborating Clinician for: _____
Name of Practitioner

I can attest that he/she is providing managed behavioral health services for network Health Plan members solely at the location(s) listed below and not in the member's place of residence. In accordance with the requirements of the laws and regulations of the State, I have established a collaborating agreement and practice protocols with_____*(Name of Practitioner),* Effective_____*(Date of Agreement).*

Location(s) of Practice:

_____

_____

_____

_____

_____

_____

This form must be completed and signed by the collaborating clinician.

_____
Signature of Collaborating Clinician

_____
Print Collaborating Clinician's Name

Signature Date: _____

Collaborating Clinician's License Number:_____

Collaborating Clinician's National Provider Identifier (NPI) (Required): _____

Collaborating Clinician's Current Address: _____