Must be completed if you are Health Professional

SUPERVISING 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

Have Questions?

www.HomeStateHealth.com OR at ***866-864-1459***