

**ALLIED PROFESSIONAL DEPENDENT PRACTITIONER**

**COLLABORATING PRACTICE INFORMATION**

\*A copy of the protocol submitted to the state licensing body may be substituted for this form\*

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| --- | --- | --- | --- | --- |
| Full Name: |  | | Degree: |  |
| Specialty: |  | License Type: |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Location where member services are provided: | | | | | | |
| Practice Name: | | |  | | | |
| Address: | |  | | | | |
| Phone: | (      )       - | | | | Fax: | (      )       - |
| Hours of Operation: | | | |  | | |

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| --- |
| Type of member services to be provided: |
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|  |
|  |

Please provide name, address and phone number of Practitioner with whom you have a collaborative agreement, if applicable (this section must be completed by those practitioners whose state license requires a protocol be entered into with a State License Physician).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Collaborating Physician (Print) | | |  | | |
| Specialty: | |  | | | |
| Address: | |  | | | |
| Phone: | (      )       - | | | Fax: | (      )       - |

|  |  |
| --- | --- |
|  |  |
| Signature of Collaborating Physician | Date |

Collaborating Physician is a Plan Participating Provider?  Yes  No