

CENTENE CORPORATION

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**Collaborative Practice Information for
Allied Health Professional Dependent Practitioners**

Name of Allied Health Professional	License Type	Specialty
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Location where member services are to be provided: _____

Type of member services to be provided: _____

Signing this agreement will indicate that the Collaborative physician will provide the following coverage if necessary: prescribing, hospitalization, & supervising.

Name of Collaborating Physician (please print)	Specialty
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Signature of Collaborating Physician	Date
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DEA# of Collaborating Physician if a DEA is not held by the Allied Practitioner _____
Or protocol if a Member needs an prescription.

Collaborating Physician is a Plan participating provider Yes No

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