Supervising Physician Statement

As the Supervising Clinician for: _____

Name of Practitioner

I can attest that he/she is providing managed behavioral health services for Sunshine 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 supervision 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 supervising clinician.

Signature of Supervising Clinician _____

Print Supervising Clinician's Name _____

Signature Date: _____

Supervising Clinician's License Number: _____

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

Supervising Clinician's Current Address: _____

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