Physician Assistant Attestation

This form must be completed and submitted with your applications for initial credentialing and re-credentialing. In lieu of completing this form, Neighborhood Health Plan of Rhode Island (Neighborhood) will accept a copy of the written agreement between the supervising physician (s) and physician assistant (PA) and a copy of PA's duties and responsibilities.

The supervising physician's expertise must encompass the population the PA is proposing to serve. When supervision is provided by multiple physicians, signatures of all supervising physicians is required.

Neighborhood requires a Federal DEA registered in the state of practice for PA's practicing at urgent care facilities and when the PA is a primary care provider with a patient panel. Patient admitting arrangement and inpatient care is required for all primary care providers.

I. Physician Assistant

Name: NPI:

Name of Practice:

Address (primary practice location):

Phone Number: Fax:

II. Practice Administrator

Name: Email:

Phone: Fax:

III. Supervising Physician

The supervising physician(s) must participate in Neighborhood's network. List the name of the supervising physician at each location where you practice:

A. Supervising Physician's Name	NPI Number
Location	
Comments:	
B. Supervising Physician's Name	NPI Number
Location	
Comments:	
C. Supervising Physician's Name	NPI Number
Location	
Comments:	

IV. Supervision *(*) indicates that response requires additional information*

1. **The supervising physician is on site when the physician assistant is seeing patients:**

   Yes ☐ No* ☐

   *If no, how can the supervising physician be reached?

2. **Is the patient given a choice of seeing the physician?**

   Initial visit: Yes ☐ No* ☐ Follow-up/subsequent visits: Yes ☐ No* ☐

   *If no, please explain:

3. **The role of the PA is clearly communicated and identifiable to patient when calling or arriving for appointments.**

   Yes ☐ No* ☐

   *If no, please explain:

4. **The PA takes part in on-call coverage rotation of the practice:**

   Yes* ☐ No ☐

   *If yes, please explain how a physician will be available for back-up to the PA, as needed:

5. **How often and how are the skills of the PA evaluated by the supervising physician?**

6. **The agreement between the supervising physician(s) and the PA is reviewed by all parties annually at a minimum.**

   Yes No*

   *If no, please explain:

7. **For PAs requesting a patient panel, detail the process for admitting and inpatient care arrangements:**

8. **Provide any additional information about the PA's role in the practice (optional).**

9. **List or attach/upload the PA's duties and responsibilities:**

I have reviewed and attest that the information given above is accurate and complete to the best of my knowledge.

Printed Name of Physician Assistant	Signature of Physician Assistant	Date

As supervising physician for the PA listed above, I have reviewed and attested that the information given above is accurate and complete to the best of my knowledge.

Printed Name of Supervising Physician	Signature of Supervising Physician	Date

If there is more than one (1) supervising physician at this location, each physician must sign below:

Printed Name of Supervising Physician	Signature of Supervising Physician	Date

Printed Name of Supervising Physician	Signature of Supervising Physician	Date

Printed Name of Supervising Physician	Signature of Supervising Physician	Date

Printed Name of Supervising Physician	Signature of Supervising Physician	Date