NURSE PRACTITIONER / PHYSICIAN AGREEMENT

Michigan Department of Community Health

For DCH Office Use Only

Provider ID Number	Provider Type
Group ID Number	Location

IMPORTANT:

- Read the Complete Instructions on the Reverse Side BEFORE completing this form.
- See the Reverse Side for PA 431 and Non-discrimination information.

This is an Agreement Between

Nurse Practitioner NAME	State RN License Number

AND

Physician NAME (MD or DO)	Prof. Title	State License No.	MI Medicaid Provider ID No.	
Street Address		City	State	ZIP Code

This Agreement Covers Services Provided at the Following Office Location:

Street Address	City	State	ZIP Code

Indicate the type of Nurse Practice you engage in:

☐ A **pediatric nurse practice**. Provide proof of specialty certification as a PNP by national credentialing entity.

☐ A **family nurse practice** . Provide proof of specialty certification as a FNP by national credentialing entity.

☐ **Other** (specify specialty):

The undersigned Nurse Practitioner and Physician agree that all covered medical services billed to the Michigan Department of Community Health (MDCH) by the nurse practitioner will be provided in collaboration with the physician pursuant to the provisions of a current collaborative practice agreement, which meets the following guidelines:

1. Key parameters of the collaborative practice agreement between the nurse practitioner and the physician are documented in writing. The written document is available upon request by agents of the State of Michigan and reasonably describes the kinds of services to be provided and, as appropriate, criteria for referral and consultation.
2. The collaborative practice agreement is mutually developed by, or approved as satisfactory to, both professionals involved.
3. Systematic formal planning and evaluation meetings occur between the undersigned nurse practitioner and the physician.
4. Periodic formal reports are made (oral or written) which assess the implementation of the collaborative practice arrangement, progress toward established objectives, and outcomes.
5. There is documented evidence of consultation as needed between the undersigned nurse practitioner and the physician.
6. There is recognition of limits of statutory and clinical authority and accountability in relation to established goals and needs of beneficiaries.

The undersigned Nurse Practitioner and Physician (MD or DO) attest that they have entered into a collaborative practice agreement effective on the date indicated below. Both parties agree to notify the Michigan Department of Community Health immediately of any changes to this agreement including dissolution of the same.

Rubber Stamp Signatures are NOT Accepted		Agreement Effective Date	
Nurse Practitioner Signature	Date	Physician Signature	Date

See Reverse Side

INSTRUCTIONS

Who Must Complete This Form:

Any nurse practitioner who wants to participate in the Medical Assistance (Medicaid) Program, Children's Special Health Care Services or the State Medical Program administered by the Michigan Department of Community Health (MDCH). The physician (MD or DO) with whom the nurse practitioner has entered into a collaborative practice agreement for the specified location.

FORM COMPLETION INSTRUCTIONS:

- Please complete ALL items on this form.
- PRINT or TYPE in BLACK INK.
- MDCH does NOT accept photocopied forms OR facsimile or rubber stamp signatures.
- True / original signatures are required.
- The physician Provider ID Number MUST be a currently active number.
- If the physician disenrolls, MDCH will also disenroll the nurse practitioner.
- You must submit an ORIGINAL of this form with a completed Medical Assistance Provider Enrollment Agreement (form DCH-1625) for EACH practice location.
- You must ALSO submit copies of the following documents with this form and the DCH-1625 for each practice location:
  - Current state registered nurse license
  - Proof of state certification as a nurse practitioner
  - Nurse practitioners must provide proof of certification by the appropriate national credentialing entity.

MAIL THIS FORM ALONG WITH ALL OTHER ATTACHMENTS TO:

PROVIDER ENROLLMENT UNIT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

If you have any questions about this form call us at **(517) 335-5492**.

AUTHORITY:	Title XIX of the Social Security Act
COMPLETION	Is VOLUNTARY, but is required if Payment from the Medical Assistance Program is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.