PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

PerformCare Psychiatrist Attestation
LSW, LCSW, LPC, LMFT, CRNP, PA and Non-Licensed Practitioners

I (Supervising Psychiatrist), _____ intend to supervise and/or employ the following person: an LSW, LCSW, LPC, LMFT, CRNP, PA or unlicensed masters level practitioner to see PerformCare HealthChoices Members and bill using my Medical Assistance Identification Number: _____.

Agency/Organization Name: _____

Supervisee Name: _____

License Number & Type, if applicable: _____

Date of Birth (for identification purposes only): _____

I understand that supervision of full time equivalent professional employees by a psychiatrist is not addressed in regulation as a separate group from other physicians and are governed by PA Code Title 49. I agree to comply with PA Code Title 49 § 18.143. Criteria for registration as a supervising physician, which establishes the requirements for registration as a physician. Or, if applicable, PA Code Title 49 chapter 25: State Board of Osteopathic Medicine, § 25.162. Criteria for registration as supervising physician, specifies that I can only supervise up to six (6) physician assistants. Additionally, I affirm that the person(s) supervised/employed will provide services in accordance the American Psychiatric Association, Principles of Medical Ethics, 2013 Edition, Section 5. I recognize that I may not ethically delegate to any non-physician any service, which the non-physician is not competent to perform or falls outside of the tasks permitted within the scope of their professional license, as applicable. Further, I understand that as a supervising psychiatrist I must be actively involved in treatment provided under my supervision. I recognize that I am fully responsible for any and all treatment provided by any staff under my supervision. I recognize that I may supervise and/or employ, Licensed Social Workers, Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Registered Nurse Practitioners, and Physician's Assistants as well as unlicensed masters level practitioners.

I further attest that:

1) I or the employer of record have verified this individual's highest level of education at the primary source. _____ Initial Here

2) I or the employer of record have verified that this individual has no Medicare or Medicaid sanctions against him/her. _____ Initial Here

3) This individual will not see PerformCare Members until notified of PerformCare approval. _____ Initial Here

4) I assure that staff I am supervising have received proper training and will receive ongoing supervision and such supervision is documented. _____ Initial Here

5) I or the employer of record have provided PerformCare, a current resume outlining the individuals work history. _____ Initial Here

6) I have provided a copy to PerformCare of the primary source of the highest level of education for each individual employed and who provides services described herein. _____ Initial here

_____	_____	_____
Supervising Psychiatrist Signature	License Number & Type	Date

_____	_____
Agency Representative Signature	Date

PerformCare Use:

Verified by: _____ Date: _____

Provider notification date: _____

Method of notice: _____

FAX (keep coversheet confirming deliver attached)
MAIL (keep letter attached)