Supervising Clinician Statement

nh healthy families

As the Supervising Clinician for: _____
Name of Practitioner

I can attest that he/she is providing managed behavioral health services for network 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: _____