GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Puerto Rico Medicaid Program

Collaborating Physician Attestation Form

This form must be submitted with enrollment applications for Physician Assistants and CRNAs enrolling in the Puerto Rico Medicaid Program.

I, _____ with the provider type of _____
Name of Collaborating Physician *Provider Type*

and license number _____, attest that I have established a collaborating agreement
License Number

with _____, effective _____ at the following
Name of Physician Assistant or CRNA *Date of Agreement*

practice location:

_____.
Address *City* *State* *Zip*

Collaborating Physician Signature			
Signature		Date	
Printed Name			

Physician Assistant / CRNA Signature			
Type of Provider			
Signature		Date	
Printed Name			

Upload this form as an attachment to your enrollment application through the Provider Enrollment Portal (PEP). Do NOT attach Protected Health Information (PHI) to your application.