



**MANAGED HEALTH SERVICES (MHS)
SUPERVISING/COLLABORATING PHYSICIAN or INDIANA HSPP ATTESTATION**

As the supervising/collaborating physician, or health service provider of psychology (HSPP), for _____ (insert name of applicant), I can attest that I supervise all plans of treatment as required by law, and he/she is providing care for MHS members solely at the following location(s):

Location I:

Location II:

Location III:

Supervising/Collaborating Physician, or HSPP Name	License Type	License Number

Signature of Supervising/Collaborating Physician or HSPP

Date

Medicaid Number

NPI of Supervising/Collaborating Physician or HSPP