

Mail to: Computer Science Corporation  
PO Box 4610  
Rensselaer, NY 12144-4610

**PHYSICIAN ASSISTANT ENROLLMENT QUESTIONNAIRE**

**Applicant Name** \_\_\_\_\_  
(Last, First, MI)

**Physician National Provider Identifier (NPI) (Required)** \_\_\_\_\_

**Physician Medicaid Provider # (Required)** \_\_\_\_\_

1. Are you working for more than one physician?  Yes  No
2. Are you working for one or more physician's group?  Yes  No
3. Are you working at more than one location?  Yes  No

If "Yes" answered for any of the above questions, complete the following:

	<u>Location</u>	<u>Provider#</u>	<u>NPI#</u>	<u>No. of Hours/Week</u>	<u>Supervising Physician</u>
a.	_____	_____	_____	_____	_____
b.	_____	_____	_____	_____	_____
c.	_____	_____	_____	_____	_____
d.	_____	_____	_____	_____	_____
e.	_____	_____	_____	_____	_____
f.	_____	_____	_____	_____	_____

4. Provide employment history for previous (2) two years. (Most recent position first. Attach additional sheets if necessary.)

<u>Date From/To</u>	<u>Location</u>	<u>Supervising Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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### SUPERVISING PHYSICIAN CERTIFICATION

**This Form Must Be Completed and Signed by Each Supervising Physician.**

1. Physician Name: \_\_\_\_\_
2. Physician License Number: \_\_\_\_\_
3. Physician National Provider Identifier (NPI) (Required): \_\_\_\_\_  
Physician Provider # (Required): \_\_\_\_\_
4. Physician Telephone Number: \_\_\_\_\_
5. Physician Current Service Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Detail the salary arrangements you have with your Physician Assistant. If the Physician Assistant is salaried by a Physician/Physician Group, attach a copy of the signed contract. If the Physician Assistant is salaried by a Hospital/Facility, attach a letter from the Chief Financial Officer of the Hospital/Facility explaining how the Physician & Physician Assistant salaries are related to the Hospitals/Facilities Medicaid Cost Report. Salary documentation is required in order to add a Supervising Physician to the Registered Physician Assistant's provider file.
7. Will the Physician Assistant practice at the same service location(s) at which you practice?  
 Yes                       No  
  
If no is checked, list locations where the Physician Assistant will practice.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Detail how supervision is carried out.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CERTIFICATION STATEMENT

In accordance with the requirements of the Law and Regulations of the State Department of Education, I have agreed to supervise Physician Assistant \_\_\_\_\_ in the manner detailed in my response to question 8.

Physician Assistant National Provider Identifier (NPI) (Required): \_\_\_\_\_

Physician Assistant Medicaid Provider # (Required): \_\_\_\_\_

Physician Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_