



of Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com

Supervising Physician Form for Nurse Practitioner or Physician Assistant

(complete one form per practitioner)

Practitioner Name applying for credentials verification (Print)

Specialty (Nurse Practitioner or Physician Assistant)

Supervising Physician Name (Print)

I, _____ supervise the above named practitioner. I review and discuss patient cases with this practitioner on a regular basis.

Protocols exist at the location where this practitioner practices? ☐ yes ☐ no

Protocols are written as required by the State law? ☐ yes ☐ no

Protocols are available to be reviewed in the practicing office? ☐ yes ☐ no

Does this applicant have admitting privileges? ☐ yes ☐ no

If not, who admits for the applicant? _____

(If not supervisor, please complete facility admitting form) Name of admitting practitioner (Print)

Facility where admitting practitioner will admit patients? _____
Name of Facility (Print)

The above information is correct. If this information changes, it is the responsibility of the Nurse Practitioner or Physician Assistant to inform BlueCross BlueShield of Tennessee, Inc., Credential Department.

Supervising Physician Signature/ Date

Applicant Signature/ Date

Note: Please return this form with your Provider Enrollment Form.