Behavioral Health Services
Quality Management Services

Medical Supervision Reporting Form

STATUS TYPE: ☐ NEW ☐ INFORMATION UPDATE *Any changes (e.g., name, registration #, supervision status, etc.) must be immediately reported to QMS/MCST.

SUPERVISEE INFORMATION: (select all that apply) ☐ County Employee ☐ Contract Employee

☐ Adult and Older Adult [AOA] ☐ Children & Youth Services [CYS] ☐ Drug Medi-Cal Organized Delivery System [DMC-ODS]

Supervisee Name: Phone #: NPI #:

Provider Type: Select Type License/Registration #:

Program/Clinic: Email:

Service Chief/Program Director:

SUPERVISOR INFORMATION:

Supervisor Name: Phone #: NPI #:

License Type: Select License Type License #:

Other: Email:

Program/Clinic: Service Chief/Program Director:

FOR MEDICAL ASSISTANT SUPERVISION ONLY

ATTESTATION REQUIREMENT

*I confirm as the Service Chief/Program Director that a licensed physician(s) and/or surgeon(s), nurse practitioner(s), or physician assistant(s) will be **physically present** in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant. The medical assistant has also been informed of these requirements.*

☐ I agree to the Medical Assistant Supervisor Attestation

Complete page 2 and list all the Medical Assistant's supervisors.

SUPERVISION TERM:

Start Date: End Date:

REASON FOR TERMINATING SUPERVISION:

☐ Termination of Employment (enter date of separation): ☐ Change of Supervisor

☐ Became Licensed/Certified (enter date of license/certification):

☐ Other, please specify:

I certify that I understand the responsibilities regarding supervision. I confirm that the provider is receiving supervision under the certification and/or license of a trained professional. I attest that the supervision and the supervisor meet the requirements as specified by the certifying and/or licensing organization. I acknowledge that the information submitted on this form is true and correct.

Supervisee Signature Date

Licensed Supervisor Signature Date

Service Chief/ Program Director Signature **(required for MA's only)** Date:

*Please complete in full and submit to: AQISManagedCare@ochca.com. For questions, please contact QMS main line: 714-834-5601.

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Additional Medical Supervisors

******List additional supervisors that have been approved to provide supervision coverage for LVNs, MAs, LPTs, & CNAs ******

SUPERVISOR INFORMATION:

Date:

Supervisor Name: Phone #: NPI #:

License Type: Select License Type License #:

Email:

SUPERVISOR INFORMATION:

Date:

Supervisor Name: Phone #: NPI #:

License Type: Select License Type License #:

Email:

SUPERVISOR INFORMATION

Date:

Supervisor Name: Phone #: NPI #:

License Type: Select License Type License #:

Email:

SUPERVISOR INFORMATION:

Date:

Supervisor Name: Phone #: NPI #:

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