CYC-I PROVIDER AGREEMENT page 1

100 Hawkins Drive Iowa City, Iowa 52242 -- Intake Line: 855-275-4444 -- Fax: 319-356-3715 -- www.cyc-i.org

Provider Group: ____

Practice Type : ___ **Family Practice Physicians** ___ **ARNPs**
___ **Pediatricians** ___ **PAs**

Address: ____

Phone/ Fax: ____

Medical Director: ____

Office Manager: ____

List individual participating practitioner's names on page 2 of this form.

Estimated total number of patients in practice: _____ **Estimated total number of children as patients:** _____

Your practice accepts: **BCBS___ United Health Care ____ Amerigroup ____ Amerihealth Caritas ____ Other ____**

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1. **We agree to participate in the Child and Youth Psychiatric Consult Project of Iowa.**
2. **We agree to participate in training at the beginning of the project and continuing education as needed during the project.**
3. **We agree to complete periodic satisfaction surveys.**
4. **We understand that the CYC-I Psychiatrist will not prescribe medications or assume care for patients discussed on a phone consult. The PCP will continue to manage the patient's care and prescribe medications.**

The undersigned represents that he/she has authority to bind the provider group to the terms herein.

Signed: ____ **Date:** ______________________

Title: ____

Printed Name: ____

CYC-I
CHILD & YOUTH PSYCHIATRIC CONSULT PROJECT OF IOWA

Participating Practitioners:

Name:	**Email:**
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