

CYC-I PROVIDER AGREEMENT

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100 Hawkins Drive Iowa City, Iowa 52242 -- Intake Line: 855-275-4444 -- Fax: 641-782-9519 -- 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: Iowa Medicaid Yes ___ No ___
 HAWK-I Yes ___ No ___

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: _____

Participating Practitioners:

Name:

Email:
