



A **xerox**  Company

Physician Assistant
Addendum of Agreement to Alaska Medicaid Provider Enrollment Application
(To be completed and signed by the Physician Assistant)

By my signature below, I understand and accept responsibility for my provider enrollment in the Alaska Medical Assistance program. I also acknowledge that I am in compliance with all federal, state medical assistance statues, regulations, policies, and procedures and I agree:

That I will immediately notify ACS, *in writing*, upon occurrence of any of the following: (1) when I am no longer meeting the requirements of my occupational license, (2) when there is a change in persons, the credentials of persons on my plan of collaboration, or my Alaska Medical Assistance provider enrollment. *I understand* that my failure to provide such notification to ACS constitutes *an automatic breach* of this agreement, making me *automatically ineligible to receive Medicaid reimbursements* as an Alaska Medical Assistance provider.

That the following individuals are listed on my plan of collaboration as my primary and alternate supervising physicians as required by 12 AAC 40.410: (attach a list if more than one alternate)

Primary Supervising Physician: _____
(Please print name) _____
NPI

Alternate Supervising Physician: _____
(Please print name) _____
NPI

Practice Location: _____

Effective date of The Plan of Collaboration: _____

Medicaid Contract ID# of Group to be associated with: _____

Group's NPI: _____

Group's Servicing Address: _____

Group's City, State Zip: _____
City State ZIP

(Use a separate addendum to add or change your group associations)

Printed Name of Physician Assistant

Signature of Physician Assistant

Date