

OMB Approval No. 0938-0685

4. Supervising Physician(s)

This section is to be completed with information about all supervising physicians. If there is more than one supervising physician, copy and complete this section for each.

A. Supervising Physician Information ☐ Add ☐ Delete ☐ Change **Effective Date:** _____

1. Name	First	Middle	Last	Jr., Sr., etc.
Social Security Number		Date of Birth (MM/DD/YYYY)		Medicare Identification Number (if applicable)
Telephone Number	(Ext.)	Fax Number (if applicable)		E-mail Address (if applicable)
()	()	()		

2. General Supervision

For overall IDTF operation in accordance with 42 CFR 410.33(b), check all that apply for the Supervising Physician reported in Section 4A1 above:

- ☐ Assumes responsibility for the overall direction and control of the quality of testing performed.
☐ Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
☐ Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

3. Type of Supervision Provided

Check the applicable box below indicating the type of supervising provided by the physician reported in Section 4A1 above for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (Definitions).

(Check applicable box) ☐ Personal Supervision ☐ Direct Supervision ☐ General Supervision

Note: Personal / Direct: If this Supervising Physician performs Personal or Direct Supervision, he/she must be currently enrolled in Medicare with the Medicare carrier to which this application is being submitted.

Note: General: If this Supervising Physician performs General Supervision, he/she must be licensed in all States where he/she will be performing the General Supervision. If this Supervising Physician is not enrolled with the Medicare carrier to which this application is being submitted, he/she must submit a copy of his/her current State license for the state in which this application is being submitted.

B. Attestation Statement for Supervising Physicians

- 1) *I hereby acknowledge that I have agreed to provide (IDTF Name) _____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in Section 1B of this Attachment (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in Section 1B of this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I cease providing the stated Supervisory Physician services, I shall immediately notify the Medicare program.*
- 2) *I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in Section 1B of this Attachment.*

CPT-4 or HCPCS Code	CPT-4 or HCPCS Code	CPT-4 or HCPCS Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) **Signature** of Supervising Physician: _____ (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) Date (MM/DD/YYYY) Signed _____