BlueCross BlueShield of Oklahoma

Advanced Practice Nurses
Collaborating/Supervising/Monitoring Physician Protocols/Duties/Scope of Practice Supplemental Questionnaire

This form applies to the following Advance Practice Nurse licensure types currently contracted and credentialed by the Health Plan and are statutorily required to be supervised/ monitored by a physician licensed to practice in the state where they currently practice and is designated as the primary collaborating/supervising physician (or an alternate physician can also provide supervision).

CRNA's *are excluded from credentialing* if they are hospital-based or work primarily in an ambulatory surgery center. However, if the CRNA works independently outside of these type facilities, they *would be required* to be credentialed and complete this form.

- Illinois: Certified Nurse Midwife (CNM), Certified Nurse Practitioner (CNP)
- Oklahoma: Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS)
- Texas: Advanced Practice Registered Nurse (APRN), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNMW)
- New Mexico: Questionnaire ***is not*** required for New Mexico.

Section 1: Collaborating/Supervising/Monitoring Physician – Illinois, Oklahoma and Texas Only

Applicant's Name:_____ **Degree:**_____ **Specialty:**_____

Collaborating/Supervising/Monitoring Physician Name: _____ **Degree:**_____

Illinois and Texas: (This physician must be licensed in the same state of practice and in the same networks as the applicant.)

Oklahoma: (This physician must be licensed in the same state of practice, in the same networks and the same specialties as the applicant.)

Collaborating/Supervising/Monitoring Physician Medical License: No:_____ **State:**_____

Alternate Collaborating/Supervising/Monitoring Physician (if applicable):_____ **Degree:**_____

Illinois and Texas: (This physician must be licensed in the same state of practice and in the same networks as the applicant.)

Oklahoma: (This physician must be licensed in the same state of practice, in the same networks and the same specialties as the applicant.)

Collaborating/Supervising/Monitoring Physician Medical License: No:_____ **State:**_____

Section 2: Protocols/Duties/Scope of Practice – Illinois, Oklahoma and Texas Only

In my current position with _____, Collaborating/Supervising/Monitoring Physician, I have reviewed, understood, agreed upon and signed along with my Supervising Physician, protocols or other written authorization which defines my duties and role as a Advanced Practice Nurse in a manner that promotes professional judgment commensurate with my education and experience. A copy of the protocols/duties/scope of practice is maintained onsite (at my primary office location).

ATTESTATION: I certify the information provided by me on this document is true, correct and complete to the best of my knowledge and belief. I understand and agree that any misstatement or omission of information concerning my collaborating/supervising physician and the established protocols/duties/scope of practice may constitute grounds for withdrawal of the application for consideration.

_____

Signature: Applicant **Date**

_____

Printed Name