Physician's Letter of Agreement

Important: *This form is required for Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Providers.*

According to Texas Health and Human Services Commission (HHSC) rules 1 TAC 354.1253 (c) and 1 TAC 354.1252 (3), certified nurse midwife (CNM) providers and licensed midwife (LM) providers are required to inform HHSC in writing of the identity of a licensed physician or group of physicians with whom the CNM or LM has arranged for referral and consultation in the event of medical complications. For purposes of this rule, "consultation" means discussion of patient status, care, and management.

Instructions: Upon initial enrollment and upon revalidation every 5 years, the CNM or LM must complete and submit to TMHP with the Medicaid provider enrollment application the following agreement affirming the CNM's supervising physician arrangement or the LM's referring or consulting physician arrangement. A separate agreement must be submitted for each physician with whom an arrangement is made. This agreement must be signed by the CNM or LM and the physician.

A new agreement must also be completed and submitted to TMHP when a new arrangement is made and when changes to an arrangement are made. *The new agreement must be submitted to TMHP within 10 business days of a cancellation or change.* This agreement must be signed by the CNM or LM and the physician or physician group representative.

Note: *The physician group representative must be a physician in the group, and the license number provided must be the license number of the physician who signs the form. A non-physician cannot sign this form.*

Provider type (Choose one):	**Date agreement is effective with the referring/consulting/supervising physician:**
☐ Certified nurse midwife (CNM) ☐ Licensed midwife (LM)	
CNM or LM Name:	**CNM or LM License Number:**
Referring/Consulting/Supervising Physician Name:	**Referring/Consulting/Supervising Physician License:**

Statement of Affirmation

I affirm that a formal agreement has been made between the physician or physician group identified above and the certified nurse midwife or licensed midwife identified above with regard to referral or consultation. All parties are in agreement that arrangements are in place to discuss the status and management of client care, and for client referral and acceptance of transfer of care if necessary.

CNM/LM Signature: ____ Date:______________________

Physician Signature: ____ Date:________________________

Please send the completed agreement to the following address:

TMHP
Attn: TMHP Provider Enrollment Department
PO Box 200795
Austin, TX 78720-0795