PIERCE COUNTY PROJECT ACCESS

Volunteer Physician Agreement - **Specialists**

Physician Name: _____ Date: _____

Address: _____

Office Phone: _____ Physicians Only Line: _____

Email: _____

Specialty(ies) Represented: _____

Key Contact for Pierce County Project Access (PCPA):

Name & Title: _____

Address: _____

Phone: _____ Email: _____

Name of Practice: _____

❑ Yes, I would like to participate in Pierce County Project Access and pledge to provide services for _____ patients **per year**. (suggested number of patients, 6-12)

Pierce County Project Access will:

- Provide case management for PCPA patients throughout their enrollment;
- Provide orientation on PCPA program to appropriate clinic staff (approximately 15 minute presentation);
- Be available via phone, email and fax to office staff to discuss status of program delivery or address any issues relating to customer service or the referral process.

By participating in Pierce County Project Access, I will:

- Provide care to Project Access patients in the same manner as non-Project Access patients by rendering all services normally and routinely provided;
- Designate one key contact in my office for PCPA (see above);
- Comply with all relevant rules and regulations associated with HIPAA;
- Submit standard HCFA 1500 to First Choice Health Network for accounting and reporting of donated services.

_____

Physician Signature

Please return via fax or email to Pierce County Project Access, Attn: Leanne, (253) 572-2470, leanne@pcmswa.org.