EmblemHealth®

55 Water Street, New York, New York 10041-8190

Attention: Credentialing Department Fax: 866-593-6986

HOSPITAL COVERAGE ARRANGEMENTS ATTESTATION:

Please complete, sign and date this form and return via fax to the number listed above.
Thank you for your cooperation.

Print Physician Name: _____

Physician Address: _____Telephone:_____

Specialty: _____Fax:_____

NY State Medical License Number: _____

Reason for Coverage Arrangements: _____

I attest that the coverage arrangement indicated on this form is complete and correct to the best of my knowledge and I understand that any falsification or misrepresentation of this information is grounds for immediate termination.

Print Physician Name_____

Physician Signature_____Date:_____

Print <u>Covering Physician</u> Name (Must be participating with EmblemHealth in the same network(s) as the physician for whom coverage is provided):
Covering Physician Name:

Physician Address:_____Telephone:_____

Specialty:_____Fax:_____

NY State Medical License Number: _____

Hospital(s) where Coverage is provided (Must be participating with EmblemHealth; Privileges must be Active/Admitting and Non-Restricted):
Hospital(s):

AP