

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 knowledge and I understand that any falsification or misreprimmediate termination.	<u>*</u>
Print Physician Name	
Physician Signature	Date:
Print <u>Covering Physician</u> Name (Must be participate network(s) as the physician for whom coverage is provide Covering Physician Name:	e
Physician Address:	Telephone:
Specialty:Fax:	
NY State Medical License Number:	
Hospital(s) where Coverage is provided (Must be purely by Must be Active/Admitting and Non-Restricted): Hospital(s):	participating with EmblemHealth; Privileges

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