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

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.