# ADMITTING HOSPITAL PRIVILEGES/COVERING ARRANGEMENT ATTESTATION STATEMENT

I, Dr. ______________________________, attest that I have active clinical admitting privileges
(Covering physician)

at Jefferson Health Plans'/Health Partners Plans' participating hospital noted below:

Primary Hospital: _______________________________________________________

Category of Privileges: _______________________________________________________

Date Privileges Granted: __________________

Specialty: _______________________________________________________

I also provide clinical coverage for: _______________________________________________________
(Physician Name)

I understand that any material misstatement or omission of fact on this form is grounds for summary dismissal from Jefferson Health Plans/Health Partners Plans as provided in the Provider Agreement.

I authorize Jefferson Health Plans/Health Partners Plans and/or its designated credentialing agent to consult with members of the medical staff or affiliate hospitals with which I am associated.

I agree a facsimile or photocopy of my signature will serve the same as the original.

| *Covering Physician Signature:* | *Physician Signature:* |
| --- | --- |
| ________________________ | ________________________ |
| *Printed Covering Physician Name:* | *Printed Physician Name:* |
| ________________________ | ________________________ |
| *Date:* _____________ | *Date:* _____________ |

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

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**JeffersonHealthPlans.com**

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