ATTESTATION OF HOSPITAL ADMISSION ARRANGEMENTS

To be completed by physician, in the event of his/her election to have member hospitalizations made by another Plan participating physician:

I,_____SPECIALTY_____, have arranged for the following practitioner(s) to provide coverage to my patients, including ability to hospitalize, in my absence:

Name: _____

Address: _____

Phone: _____

Specialty: _____

Name: _____

Address: _____

Phone: _____

Specialty: _____

To be completed by practitioner(s) providing coverage:

NOTE: Covering Practitioner(s) MUST be a Plan provider(s)

SIGNATURE OF PRACTITIONER REQUESTING COVERAGE

_____

Signature Print Name

_____

Date

SIGNATURE OF PRACTITIONER(S) ACCEPTING COVERAGE

agree to provide coverage for the above named practitioner, including ability to hospitalize Plan patients.

I

Practitioner accepting coverage:

_____

Signature Print Name

_____

Date

_____

Name of main admitting Hospital

Practitioner accepting coverage:

_____

Signature Print Name

_____

_

Date

_____

_

Name of main admitting Hospital

PLAN MUST BE NOTIFIED IN WRITING OF ANY CHANGE IN HOSPITAL COVERAGE ARRANGEMENTS

2012