HEALTH PARTNERS PLANS
ADMITTING HOSPITAL PRIVILEGES/COVERING ARRANGEMENT ATTESTATION STATEMENT

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

at the Health Partners 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 Health Partners Plans as provided in the Provider Agreement.

I authorize 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: _____

Printed Covering Physician Name: _____

Date: _____

Physician Signature: _____

Printed Physician Name: _____

Date: _____