Hospital Coverage Arrangements Attestation

Please complete, sign, and date this form and return via fax to **212-510-5268** or via email to **credrecredprocess@emblemhealth.com. 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 Covering Physician 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):

RESET PRINT SUBMIT