**ADMITTING HOSPITAL PRIVILEGES/COVERING ARRANGEMENT
ATTESTATION STATEMENT**

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

at Jefferson Health 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 as provided in the Provider Agreement.

I authorize Jefferson Health 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: _____________