



Instructions: Complete **Section 1** or **Section 2** to verify admitting/coverage arrangements.

Section 1: Practitioners Without Admitting Arrangements *(please print)*

I'm attesting, I do not have active admitting privileges at a participating network hospital and my practice will be confined to outpatient care. I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer member care to a participating physician or hospitalist who has active admitting privileges at a participating network hospital.

I will facilitate hospital admissions for my patients as follows:

Option A: Through the participating practitioner indicated below, of the same specialty who has active admitting privileges at _____ Hospital.

Provider Name	Specialty
Admitting Provider Name	Admitting Provider NPI
Admitting Physician Signature	Date
Practitioner Signature	Date

Section 2: Practitioners with Transfer Agreements or Hospitalist Program

I will facilitate hospital admissions for my patients as follows:

Option B: I have an arrangement with a Hospitalist Program that has agreed to perform admissions for my patients. *(Enclose such agreement)*

Hospital Name	Address		
City	State	Zip Code	Phone
Practitioner Signature	Date		

PLEASE NOTE - This requirement **does not** apply to providers practicing the following specialties: Chiropractor, Dermatology, Pathology, Radiology, Occupational Therapy, Physical Therapy, Nutritionists/Dietitians, Acupuncturists.

Completed Form and Additional Documentation (if applicable) can be sent to:

Att: Credentialing Dept. • 220 E 42nd Street, 3rd Floor • New York, NY 10017

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