KEYSTONE 65 SELECT NETWORK HOSPITAL PRIVILEGES ATTESTATION

Section 1:

Practitioner Name:____

Specialty:____

Primary Hospital Affiliation:____

Dates of Affiliation: _______/_______/_______ - Present
(MM DD YYYY)

Department: ________________ Staff Category: _________________________________

Are admissions within the scope of your privileges at this hospital? _____YES _____NO

Are your privileges in good standing at this hospital? _____YES _____NO (If "NO" explain below)

____
____
____

I certify that the information contained in this document is complete and accurate.

____ _______/_______/_______
(Practitioner's Signature) (MM DD YYYY)

Section 2:

If admissions are not within the scope of your privileges, you must have one of the following:
1. Arrangement for a participating practitioner within your same or similar specialty to admit patients to a participating Keystone 65 Select network hospital on your behalf if necessary.

Please have the covering practitioner complete the section below:

I, Dr._____________________________________ will admit patients to_______________
(Hospital name*)

on behalf of Dr.______________________________________.

I am a participating practitioner with unrestricted admitting privileges at this network hospital.

Full name ____ (Please print)

Degree ____ (Please print)

Specialty: ____

____ _______/_______/_______
(Covering Practitioner's Signature) (MM DD YYYY)

2. Arrangement for admissions with a participating hospitalist group to a participating hospital.

____will admit patients to ____________________
(Name of hospitalist group) (Hospital name*)

on behalf of Dr. ______________________________

____ ________/___/_____ Hospitalist
Group Medical Director/Chief Medical Administrator (MM DD YYYY)
(Note: signature must be a physician)

*Must be a hospital that is participating in the Keystone 65 Select network

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