Hospital Admitting Arrangement Form

I confirm that I **do not** have admitting privileges at a participating hospital and will rely on one of the options below for referrals/admissions of patients.

☐ I confirm that a provider within my primary practice/group will admit patients on my behalf.

Admitting Provider: _____

Admitting Hospital: _____

☐ I attest that I will refer my patients to inpatient levels of care using hospitalists at the following facilities listed below:

Primary Hospital Name: _____

Secondary Hospital Name: _____

Provider's Name: _____

Date: _____