Change in Hospital Privileges

The information entered into this form is subject to review and approval by UPMC Health Plan. Submitting this informationchange form does not mean it is automatically uploaded to our system. Any questions resulting from our review must be addressed before the change is approved. Providers are required to maintain hospital privileges with a participating facility as a condition of their contract with UPMC Health Plan.

Date:* _____ Name of provider:* _____

☐ PCP ☐ Ob-gyn ☐ Specialist/Dental/Vision ☐ Ancillary (medical only) ☐ Chiropractor ☐ Extenders (CRNP, CNM, CRNA)

Contact name:* _____ Provider number: _____

Phone:* _____ Tax ID Number:* _____ Email:*_____

** Required information*

Changing the hospital affiliation of the doctor may affect the products he or she can provide.

Affiliations to Remove:

Hospital: _____ Privileges: _____ Effective Date: _____

Hospital: _____ Privileges: _____ Effective Date: _____

Hospital: _____ Privileges: _____ Effective Date: _____

Affiliations to Add:

Hospital: _____ Privileges: _____ Effective Date: _____

Hospital: _____ Privileges: _____ Effective Date: _____

Hospital: _____ Privileges: _____ Effective Date: _____

Consent to Verify Hospital Privileges form must be returned if adding an affiliation.

Admitting arrangement: ☐ Yes ☐ No

Name of participating physician or hospitalist group: _____

Return completed form by email, fax, or mail to:

UPMC Health Plan
Network Development & Provider Data Maintenance Dept.
U.S. Steel Tower - 14th Floor
600 Grant Street
Pittsburgh, PA 15219
Fax: 412-454-8225

providernetworkinquiries@upmc.edu
hpdental@upmc.edu (dental providers)
hpvision@upmc.edu (vision providers)

UPMC Health Plan

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CONSENT TO VERIFY HOSPITAL PRIVILEGES

I acknowledge and agree that UPMC HEALTH PLAN (UPMC HP) has a valid interest in obtaining and verifying information concerning my hospital privileges in determining whether I continue to meet the obligations set forth in my Provider Participation Agreement for the provision of services to members.

Accordingly, intending to be legally bound:

1. I authorize UPMC HP, and/or its credentials verification organization (CVO), to consult with hospital administrators or members of hospital staff or its credentials verification organization (CVO), to obtain and verify information concerning my hospital privileges. This may include obtaining and verifying professional competence, ability to work with others, character, and moral and ethical qualifications.

2. I consent to the release by any source, person or organization to UPMC HP of all information that reasonably may be relevant to an evaluation my hospital privileges including of my professional competency, character, and moral and ethical qualifications, including any information relating to any disciplinary action, suspension, or curtailment of privileges and hereby release any such person or organization providing such information from any and all liability for doing so.

3. I release UPMC HP and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my hospital privileges.

4. I acknowledge that a photocopy of this permission will serve as the original.

Signature _____ Name (please print) _____ Date _____

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

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