HOSPITAL ADMITTING ARRANGEMENTS ATTESTATION
HOSPITALIST

Medi-Cal IPAs are required to contract with a dedicated Hospitalist at the Hospitals where the IPA receives membership assignment and a Hospitalist exists. If IEHP Direct has a Hospitalist contracted at the same hospital, the IPA must contract with the same Hospitalist. All other arrangements are subject to IEHP review and approval. The Hospitalist will be assigned to admit patients on behalf of the IPA, for those Primary Care Providers (PCPs) who do not hold their own privileges at the respective hospital.

DEFINTION:

Hospitalist: A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary care doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary care doctor when you leave the hospital.[1]

- Hospitalist do not need to be credentialed. They are Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.[2] Therefore, the Practitioner is credentialed with the Hospital.

This letter shall serve as formal notification of:

_____ ‘s written arrangement with
Medi-Cal IPA Name

_____ , who meets the definition of a Hospitalist,
Hospitalist Name

and attests that a written arrangement is in place that includes the following:

- IPA has a mutually agreed upon agreement with the Hospitalist listed above, which is subject to IEHP review, upon request.
- The agreement stipulates a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the IPA’s knowledge of pending termination
- The agreement specifies that bills for services rendered are submitted to and paid by the IPA

[1] CMS.gov (Glossary).
[2] NCQA, 2020 HP Standards and Guidelines, CR 1, Element A.

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- Hospitalist admitting privileges and will be providing PCP coverage at the following hospitals:

☐ Arrowhead Regional Medical Center
☐ Barstow Community Hospital
☐ Community Hospital of San Bernardino
☐ Corona Regional Medical Center
☐ Chino Valley Medical Center
☐ Desert Regional Medical Center
☐ Desert Valley Hospital
☐ Eisenhower Medical Center
☐ Hemet Valley Medical Center
☐ Inland Valley Regional Medical Center
☐ John F. Kennedy Memorial Hospital
☐ Montclair Hospital Medical Center
☐ Parkview Community Hospital Medical Center
☐ Pomona Valley Hospital Medical Center
☐ Rancho Springs Medical Center
☐ Redlands Community Hospital
☐ Riverside Community Hospital
☐ Riverside County Regional Medical Center
☐ San Antonio Regional Hospital
☐ San Gorgonio Memorial Hospital
☐ St. Bernardine Medical Center
☐ Temecula Valley Hospital
☐ Victor Valley Global Medical Center

HOSPITALIST INFORMATION:

_____
HOSPITALIST NAME

_____ _____
AGE RANGE **GROUP NPI**

_____ _____
PHONE **FAX**

_____ _____
NAME AFFILIATED WITH TIN **TAX ID NUMBER (TIN)**

By signing below, I hereby affirm that the information submitted is true, current and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of this hospital arrangement.

_____
IPA ADMINISTRATOR NAME

_____ _____
IPA ADMINISTRATOR SIGNATURE **DATE**