

Practitioner Continuity of Care Statement



Practitioners *With* Admitting Arrangements (please print)

Name (Last, First)	Specialty
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Practitioners are required to arrange for an admission, when medically appropriate, for the care they have provided to patients.

As an MVP Health Care-participating practitioner, I will arrange continuity of care to MVP patients for the entire episode of required medical treatment including the inpatient and outpatient setting.

I will facilitate hospital admissions for my MVP patients as follows (check one option):

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

Practitioner Name	Specialty		
Address	City	State	Zip Code
Phone			
Admitting Physician Signature	Date		

Option B: I have an arrangement with a Hospitalist Program that has agreed to perform admissions for my MVP patients.

Hospitalist Program Name	Specialty Covered		
Address	City	State	Zip Code
Phone			
Hospitalist Program Administrator Signature	Date		

Practitioner Signature

Please return this completed form to providerenrollment@mvphealthcare.com.

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Practitioners *Without* Admitting Arrangements *(please print)*Name *(Last, First)*

Specialty

MVP Health Care endorses the principle, in accord with medicine's ethical mandate, to provide for continuity of care and the ethical imperative that physicians not abandon their patients, and that physicians must provide ongoing care for the entire episode of required medical treatment including the inpatient and outpatient setting.

As an MVP-participating practitioner, I will arrange continuity of care to MVP patients for the entire episode of required medical treatment, including the inpatient and outpatient setting. Practitioners are required to arrange for an admission when medically appropriate for the care that they have provided to their MVP patients.

My current scope of practice entails the following *(include any procedures performed, if any):*

I will provide continuity of care to my MVP patients in the following manner *(please describe in detail):*

Practitioner Signature

Date