Provider Recredentialing

If you are currently a participating provider and received a letter for notification of recredentialing, be sure to review and attest to the information provided. We will not be able to complete the recredentialing process until the completed form is received by our credentialing department.

Thank you for your support and compliance with this process.

Provider Information

Title: (Mr./Mrs./Ms./Dr.)

First Name:

Last Name:

Individual NPI:

Attestation Statement and Authorization to Release Information

I attest to be a practitioner in the Health Partners Plans/Jefferson Health Plans provider network as a

Primary Care physician ☐

Specialist ☐

Allied Health provider ☐

I certify that all of the information that I have submitted in connection with the application is true, accurate and complete. I understand that Health Partners Plans/Jefferson Health Plans will rely on this information to evaluate my participation in the Health Plan.

I understand and agree that I am to adhere to and abide by the terms and conditions of this program(s) and any/all agreements I have or will in the future enter into with the Health Plan.

I understand that any material misstatement or omission of fact on the application is grounds for action by the Health Plan, including but not limited to summary dismissal from the Health Plan as provided in the Provider Agreement.

I attest to having, in the amounts required by the State of Pennsylvania, current, valid malpractice insurance coverage and all other applicable professional insurances.

I agree to adhere to the code of ethics of the following professional organization:

--Select One--

1-888-991-9023
1101 Market Street, Suite 3000
Philadelphia, PA 19107
JeffersonHealthPlans.com

I authorize Health Partners Plans/Jefferson Health Plans and/or its designated credentialing agent to consult with members of the medical staff, affiliate hospitals, professional liability carriers, and healthcare facilities with which I have been associated. In addition, this authorization includes consultation with other healthcare professionals who may have information bearing on my competency, character, physical health status, emotional health status, and ethical aspects of my professional practice.

I authorize the release of such information to the Health Plan and/or its designated credentialing agent upon request. I agree a facsimile or photocopy of my signature will serve the same as the original.

I attest that I have clinical admitting privileges at a Health Partners Plans/Jefferson Health Plans participating hospital noted on my CAQH or PA Standard application.

I agree to release all Medical Assistance records pertaining to sanctions and/or settlements to the Health Plan and the Pennsylvania Department of Human Services.

I agree to attend at least one Health Plan sponsored provider education training session annually.

Attestation Full Name:

Attestation Signature:

Attestation Date:

**Please email completed forms to: credentialing@jeffersonhealthplans.com

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