Send completed form by fax or email to the following:

CMS Provider Management
Email: cmsproviderhelp@floridahealth.gov
Fax: (850) 487-1279

CMS Physician Hospital Privileges Designation

I, _____, understand that I will be required as a CMS credentialed physician to provide 24-hour, 7 day a week health care access for my CMS patients. Therefore, I have entered into an agreement with **one** of the following (please initial one):

Option 1: _____ Initial	An active CMS physician who has admitting privileges. The **physician** named below is a CMS contracted and credentialed physician who has admitting privileges at a Florida licensed hospital. The below named physician agrees to admit and oversee in-patient care for CMS enrollees assigned to me who require hospitalization. _____ _____ _____ Admitting Physician Signature Print Name Date
Option 2: _____ Initial	_____ (Florida licensed hospital name) The **hospital** named above agrees to use employed pediatric hospitalists to admit and oversee in-patient care for CMS enrollees assigned to _____ who require hospitalization. _____ _____ _____ Hospital Faculty Signature Print Name Date

By instituting this agreement, I affirm my desire to ensure that all children with special health care needs enrolled in CMS have a medical home with an assigned CMS primary care provider and have access to a continuum of services within the CMS network of providers.

_____ _____
Physician Applicant Signature Date