Locum Tenens Credentialing Form and Attestation (1)

WellSense HEALTH PLAN

If you are a locum tenens provider:

- Please attach a malpractice face sheet
- If you do not have hospital privileges, please attach coverage arrangements for admitting WellSense Health Plan members.

Hospital Affiliation: _____ Dates Affiliated: _____

Department Specialty: _____

Category: _____

Name of Department Chair: _____

Dates for Locum Tenens (WellSense Health Plan allows up to 90 days):

From: _____ To: _____

I, _____, hereby attest that this information is true and complete.

Signature: _____

Date: _____

(1) To be submitted with HCAS Enrollment Form and Provider Data Form