

Unison Health Plan of Ohio

PHYSICIAN ON-CALL COVERAGE AGREEMENT

Date: _____

Originating Provider Name: _____ Unison Health Plan of Ohio ID#: _____

Expected Date(s) of Absence: _____

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Originating Provider

As a Unison Health Plan of Ohio participating Provider, it is my contractual responsibility to be accessible to Unison Health Plan of Ohio Members twenty-four (24) hours a day, seven (7) days a week. In my absence, I have arranged for the following provider to assume responsibility for my practice: _____

Covering Physician Name (Please Print)

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Covering Physician

While providing on-call coverage I will:

- Provide medical care only when covering and will refer the Member back to the original Provider for follow-up care.
- Contact the Plan Utilization Management (UM) Department in situations requiring medical attention beyond the scope of my practice. In these cases, the Plan UM Department will arrange for the Member to be treated by a Plan participating Consulting Provider.
- Notify the Plan UM Department within 24-hours after being made aware of an emergency or facility admission.
- Attempt to notify the original Provider or obtain UM authorization to admit a Member.
- Attempt to admit a Member to Unison Health Plan of Ohio facilities only.
- Not bill a Member of Unison Health Plan of Ohio for any services.

I affirm that:

- I have malpractice insurance meeting at least the minimum State of Ohio requirements.
- I am at all times acting as an independent contractor.
- Unison Health Plan of Ohio will not be responsible for any alleged acts of professional negligence which are asserted against me in the course of my professional service.
- My license(s) to practice medicine has never been suspended, revoked, or otherwise adversely affected.
- I have never been under investigation, indictment or prosecution for any offense related to the delivery of an item or service under Medicare or Medicaid programs.
- I maintain staff privileges at the following hospitals; and that these privileges have not in any way been reduced, restricted or revoked:

Hospital Name (Please Print)

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ORIGINATING PROVIDER SIGNATURE

COVERING PROVIDER SIGNATURE

MEDICAL DIRECTOR SIGNATURE _____ DATE: _____

Fax this form to the Provider Relations Department at 614.794.0562