

## **CHOC PSF Hospitalist Division**

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In order to update your profile to reflect the CHOC PSF as your hospitalist preference for admitting patients to CHOC, please complete this form, sign and fax back to **714-532-8374**. This information will be maintained in the Physicians Profile Section of the CHOC Emergency Department tracking and registration system for use in the Emergency and Admitting Departments.

**\*Our FAXED confirmation of this completed form will serve as your confirmation letter for your CHDP Credential Renewal required every three (3) years of physicians who opt to have their CHDP qualified hospitalized patients managed by Hospitalists during in-patient stays.**

<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/CHDPForms.aspx> Form #DHCS 4491

### **PCP Information**

Last Name:	First Name:
Group Name:	
Office Address:	
City, State & Zip:	
Office Phone:	Office Fax:
Alternate Phone/Pager:	
Email:	
Specialty:	

Patients covered by a health plan with contracted hospitalist coverage will be admitted to the appropriate hospitalist team based on their insurance coverage.

In order to best serve your needs please indicate your preferences as follows:

I prefer that my patient be attended by a CHOC PSF Hospitalist.

Additional Preferences:

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**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please fax this form to **(714) 532-8374** ~ Receipt confirmation will be sent  
Joyce Morell, Director Physician Relations