



Application Addendum

Supervising Physician and Sponsoring Physician Form

Dear Provider,

Thank you for your interest in becoming a provider with First care Health plan. It is First Cares requirement that physicians without privileges have sponsoring physician who is a physician provider of a like specialty and scope of practice.

The Sponsor and Supervising Physician addendum is accepted as fulfilling your obligation to have a sponsoring agreement. It will also be used to verify if the sponsoring physician is a participating provider of like specialty and scope of practice.

In order to continue with the credentialing process it is imperative that you return the Application addendum as soon as possible. If we have not received the information for your application it could be discontinued from the credentialing process.

Please fax the addendum to the number below:

Fax: 806-993-9363 or email to creds@firstcare.com

If you have any questions, please feel free to contact us at creds@firstcare.com

Thank you,

FirstCare Health Plans
FirstCare Credentialing Department



Applying Practitioner Name: _____

Practitioner NPI: _____

Midlevel Practitioners are required to have an in-network (Participating) supervising physician in a like specialty and scope of practice, and that their supervising physician maintain hospital privileges or admitting arrangements for admissions at an in network hospital.

Identify by name, address and specialty, the physician with whom you have an agreement

Supervising Physician

Supervising Physician Name: _____

Supervising Physician NPI: _____

Practicing Specialty: _____

Office Phone Number: _____

Admitting Hospital: _____

Hospital Address: _____

Physicians without their own hospital admitting privileges are required to have a sponsoring physician of like specialty and scope of practice to admit patients to an in network hospital.

Sponsoring Physician (Admitting Physician)

Sponsoring Physician Name: _____

Sponsoring Physician NPI: _____

Practicing Specialty: _____

Office Phone Number: _____

Admitting Hospital: _____

Hospital Address: _____