

**IEHP PCP Leave of Absence Coverage Form**

In compliance with IEHP Provider Policy **18.I Leave of Absence,** which requires an adequate coverage plan for all leaves of absence from my practice greater than two (2) weeks,

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have entered into an Agreement with

 **(PCP Name)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who will be available to my

 **(Covering Provider’s Name /or Group Name)**

IEHP patients for direction of care during my absence.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_can be reached at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 **(Covering Provider’s Name/ Group Name) (Telephone #)**

located at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Address)**

In the event I enter into a different Agreement for coverage during a leave of absence, I will

provide IEHP sixty (60) days advance written notification who the covering Provider will be during any future leaves of absence.

I understand the information provided above will be utilized by IEHP when directing my IEHP patients during any leave of absences greater than two (2) weeks. If IEHP does not receive notification of coverage for a leave of absence greater than two (2) weeks, my panel may be frozen until a coverage plan is received or pending my return. A leave of absence greater than ninety (90) days could result in a transfer of assigned Members to another PCP.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**