

Transition of Care Form

We are pleased you have chosen Providence Health Plan for your health care and look forward to working with you. As you transition to our Plan it is very important for us to understand any special health needs or medical conditions that you or your family members may have. For example, if you are currently receiving care for medical conditions (such as pregnancy in the third trimester, chemotherapy, radiation therapy, or preparing for an organ transplant), have special medication needs or have surgery scheduled in the next few weeks, we can help with your questions or concerns. One of our Nurse Case Managers will contact you. Please complete the following information so that we may take an active role in assisting you with your health care needs.

MEMBER INFORMATION				
Last Name	First Name	M.I.	DOB	Sex
Address			Day Phone	
City	State	Zip Code	Evening Phone	
Employer/Group Name			Employee Name	
Relationship to Employee		Physician	Physician Phone No.	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
<ul style="list-style-type: none"> • Is the member currently receiving treatment for any acute conditions or trauma? • Is the member scheduled for surgery or hospitalization during the next 90 days? • Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care, or a candidate for organ transplant? • Is the member receiving treatment as a result of a recent major surgery? • Is the member expected to be in the hospital during the next 90 days? • Is the member pregnant? If yes, when is the due date? _____/_____/_____ 			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member currently enrolled in a disease management program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please describe the condition and treatment plan for which the member requests care coordination:				
AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION				
<p>I hereby authorize my physician, healthcare practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Providence Health Plan any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder for purpose of review, investigation, quality management, research, or evaluation of an application or claim. I authorize Providence Health Plan or its agents, designees, or representatives to disclose to a hospital, health care service plan, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable Providence Health Plan to process claims.</p>				
Signature: _____			Date: _____	
<p>All information provided on this form will be kept CONFIDENTIAL, and used only for transition of medical care purposes.</p> <p>Please fax this form to 503.574.8171 Attention: Case Management Department</p>				