

CARE COORDINATION REQUEST FORM



ATTN: Health Services Dept.
 PO Box 7068
 Eugene, OR 97401-0068
 (541) 684-5584 • (888) 691-8209
 Fax (541) 686-2051
 www.pacificsource.com

If you are a new member currently involved in an active treatment plan, you may have concerns about whether you will be able to continue treatment under PacificSource coverage. We understand your concern and will contact you (or your designee) to discuss your ongoing care needs. **Please complete all applicable sections below. Please type or print legibly in ink.**

Employer/Group Name					
Employee Last Name		First Name		M.I.	DOB
Address			City	State	Zip Code
					Home Phone No.
CURRENT AND PRIOR INSURANCE COVERAGE INFORMATION					
Name of Insured		Insurance Company Name and Policy Number		Group Policy No.	
					Will coverage remain in effect while covered by PacificSource?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
MEMBER INFORMATION					
Name of Member		Relationship to Employee		Sex	DOB
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
				Physician	Physician Phone No.
<ul style="list-style-type: none"> • Is the member currently receiving treatment for any acute conditions or trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the member scheduled for surgery or hospitalization during the next 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care, or a candidate for organ transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the member receiving treatment as a result of a recent major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the member expected to be in the hospital during the next 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No • Is the member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when is the due date? ____/____/____ • 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: _____					

HEALTH INFORMATION ACKNOWLEDGEMENT AND DECLARATION					
<p>I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment, or for business operations necessary to administer healthcare benefits; or as required by law.</p> <p>Health information requested or disclosed may be related to treatment or services performed by:</p> <ul style="list-style-type: none"> • A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; • A clinic, hospital, long-term care, or other medical facility; • Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or; • An insurance carrier or group health plan. <p>Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for this information.</p>					
Signature _____			Date _____		