

CARE COORDINATION REQUEST FORM



OREGON

If you are a new member currently involved in an active medical or drug 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 and return the form as soon as possible to:**

PacificSource Health Plans
ATTN: Health Services Dept.
 PO Box 7068
 Eugene, OR 97401-0068
 Fax (541) 225-3625

If you have questions, please call Health Services at (541) 684-5584, or toll-free at (888) 691-8209

Employer/Group Name			Date PacificSource coverage will be effective ____/____/____	
Employee Last Name	First Name	M.I.	DOB ____/____/____	
Address		City	State	Zip Code
				Daytime Phone No.
CURRENT AND PRIOR INSURANCE COVERAGE INFORMATION				
Name of Insured	Insurance Company Name and Policy Number		Coverage Dates	
			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	Physician
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
Physician Phone No.				
Is the member:				
• Currently receiving treatment for any conditions or trauma? If yes, please describe: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Scheduled for surgery or hospitalization during the next 90 days? If yes, please describe: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Receiving chemotherapy, radiation therapy, or other cancer therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Enrolled in home care or hospice?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• A candidate for organ transplant?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Receiving treatment as a result of a recent major surgery?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Currently enrolled in a disease management program? If yes, please describe: _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Currently pregnant? If yes, when is the due date? ____/____/____			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you interested in receiving information about the PacificSource Prenatal Program?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Currently using a specialty pharmacy? If so, which one? _____			<input type="checkbox"/> Yes	<input type="checkbox"/> No

List the names of prescription medication the member regularly takes (you do not need to list the dosage, nor do you need to list any over-the-counter or herbal medications): _____

Please describe the condition and/or treatment plan for which the member requests assistance in transitioning to PacificSource: _____

AUTHORIZATION TO REQUEST/RELEASE INFORMATION

I, the undersigned, hereby authorize PacificSource Health Plans to request and/or disclose health information about me or my dependents (specifically those persons who are listed for benefits coverage on this enrollment form) for the purpose of facilitating my health care benefits, including the administration, payment and business operations related to those benefits.

Health information requested or disclosed may be related to treatment or services sought from, or provided by:

- A physician, dentist, pharmacist, or other healthcare practitioner;
- A clinic, hospital, long-term care, or other medical or nursing facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or:
- An insurance carrier or group health plan.

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 psychotherapy notes. A separate authorization will be used to obtain information related to psychotherapy, chemical dependency, and HIV status, when applicable.*

Signature

Date