

CARE COORDINATION REQUEST FORM



**IDAHO/
MONTANA**

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.
 408 E Park Center Blvd, Suite 100
 Boise, ID 83706
 Fax (208) 333-1597

If you have questions, please call Health Services at (208) 333-1563

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? ____/____/____ 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