PacificSource HEALTH PLANS

Care Coordination Request Form

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, Springfield, OR 97475-0068
Email: MSSTeamCommercial@pacificsource.com
Fax: (541) 684-5486
Questions? (888) 977-9299; TTY (800) 735-2900

Enrollment Information

Employer/Group Name _____ Date PacificSource coverage will be effective ____/____/____

Employee Last Name _____ Employee First Name _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Daytime Phone _____

Email Address _____

Current and Prior Insurance Coverage Information

Name of Insured _____ Insurance Company Name _____

Insurance Company Policy Number _____ Coverage Dates _____/_____/_____ to _____/_____/_____

Will coverage remain in effect while covered by PacificSource? ☐ Yes ☐ No

Member Information

Name of Member _____ Relationship to Employee: ☐ Self ☐ Spouse ☐ Dependent

Sex _____ Date of Birth _____ Physician _____ Physician Phone _____

Is the member:

☐ Yes ☐ No Currently receiving treatment for any conditions or trauma?
If yes, please describe: _____

☐ Yes ☐ No Scheduled for surgery or hospitalization during the next 90 days?
If yes, please describe: _____
If yes, at which hospital or facility? _____

☐ Yes ☐ No Receiving chemotherapy, radiation therapy, or other cancer therapy?

☐ Yes ☐ No Enrolled in home care or hospice?

☐ Yes ☐ No A candidate for organ transplant?

☐ Yes ☐ No Receiving treatment as a result of a recent major surgery?

☐ Yes ☐ No Currently enrolled in a disease management program?
If yes, please describe: _____

☐ Yes ☐ No Currently pregnant?
If yes, when is the due date? _____

☐ Yes ☐ No Are you interested in receiving information about the PacificSource Prenatal Program?

☐ Yes ☐ No Currently using a specialty pharmacy?
If so, please include specialty pharmacy, specialty medication, and prescribing doctor.

_____

List the names of prescription medication the member regularly takes (you don't need to list any over-the-counter or herbal medications). For each, include the name and phone of the prescribing doctor:

Medication Name	Prescribing Doctor	Phone

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 healthcare 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 _____