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:**

Oregon:
PacificSource Health Plans
ATTN: Health Services Dept.
PO Box 7068, Springfield, OR 97475-0068
Email: healthservices@pacificsource.com
Fax: (541) 225-3625
Questions? (541) 684-5584 or (888) 691-8209

Idaho and Montana:
PacificSource Health Plans
ATTN: Health Services Dept.
408 E Park Center Blvd, Suite 100, Boise, ID 83706
Email: healthservices@pacificsource.com
Fax: (208) 333-1597
Questions? (208) 333-1563

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 ____________________

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: ____________________

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 ______________