PacificSource HEALTH PLANS

A provider or facility you use is leaving the PacificSource network.

Although their contract is ending, we want to be sure your ongoing care continues without problems. Completing the attached Care Access and Handoff Form lets us:

1. **Check if you qualify to keep seeing this provider**—for example, if you are pregnant, being treated for a serious illness, or healing from surgery.
2. **Approve more visits at your in-network benefit level** for a short time (up to 90 days, or longer in some cases) while you finish treatment or move to another provider.
3. **Assign someone (nurse case manager or care navigator) to help with medical records,** making appointments, transportation, and support during the change.

What you need to do:

- Fill out Sections A–D on the next page with your treatment details.
- Sign Section F and return the form **within 90 days** of the date on your provider's termination notice. Incomplete forms may delay processing.
- Choose the submission method most convenient for you:

Fax
541-385-3123

Mail
PacificSource Health Plans
Attn: Care Access Request
PO Box 7068
Springfield, OR 97475

Care Access and Handoff Form

PacificSource HEALTH PLANS

Section A – Member Information

Member name _____ Member ID _____

Date of birth (MM/DD/YYYY) _____ Phone _____

Email _____

Primary address _____

City _____ State _____ Zip _____

Section B – Terminating Provider Information

Provider/Facility name _____

Specialty _____ Phone _____

Address _____

City _____ State _____ Zip _____

Section C – Reason for Care Access and Handoff Request

- ☐ Pregnancy (due date: _____)
- ☐ Serious & complex condition (such as chemotherapy, radiation)
- ☐ Terminal illness (expected to live less than 6 months)
- ☐ Ongoing inpatient or institutional care
- ☐ Required surgery scheduled (Date: _____)
- ☐ Follow-up care for a recent surgery (Date: _____)
- ☐ Organ or bone-marrow transplant (Which type: _____)
- ☐ Behavioral health / substance-use disorder treatment (last visit within last 45 days)
- ☐ Continue to see primary care provider (120-day grace)

Section D – Treatment Details

Health issue being treated _____ Date treatment began _____

Planned end date _____ Current/planned services _____

Authorization number (if any) _____ Number of visits requested _____

Section E – Preferred Contact Method

☐ Phone ☐ Email ☐ InTouch Message

Section F – Signatures

Member/Legal guardian signature _____ **Date** _____

Treating Provider signature (optional) _____ **Date** _____

Fax: 541-385-3123 **Mail:** PacificSource Health Plans, Attn: Care Access Request, PO Box 7068, Springfield, OR 97475