CARE COORDINATION REQUEST FORM

PacificSource HEALTH PLANS

LEGACY HEALTH

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
Springfield, OR 97475-0068
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?
			☐ Yes ☐ No

MEMBER INFORMATION

Name of Member	**Relationship to Employee**	**Sex**	**DOB**	**Physician**	**Physician Phone No.**
	☐ Self ☐ Spouse ☐ Dependent				

Is the member:

- Currently receiving treatment for any conditions or trauma? ☐ Yes ☐ No
  If yes, please describe:_____
- Scheduled for surgery or hospitalization during the next 90 days? ☐ Yes ☐ No
  If yes, please describe:_____
- 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

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

_____

_____

_____

continued on reverse

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