Care Coordination Request Form

PacificSource HEALTH PLANS

Welcome to PacificSource! If you are a new member with an active medical or drug treatment plan, you may have questions about continued treatment through your PacificSource coverage. We understand and are here to help you or your covered family members. By completing this form, we will be able to contact you (or your designee) to discuss your care and answer any remaining questions. First, **please complete the applicable sections below and return this 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 711

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 _____

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 Assigned at Birth (M/F) ____ Gender Identity* _____ Date of Birth _____

Physician _____ Physician Phone _____

*__Gender identity__ (optional): **A-**Agender, **B-**Boy, **GF-**Gender fluid, **GN-**Gender nonconforming, **GQ-**Genderqueer, **G-**Girl, **M-**Man, **NB-**Non-binary, **NL-**Not listed, **P-**Prefer not to answer, **Q-**Questioning or unsure, **TG-**Third gender, **TM-**Trans man, **TW-**Trans woman, **T-**Transgender, **TS-**Two-spirit, **W-**Woman

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. Requesting brand name medication (even when medically necessary) may require additional review for coverage and may result in a higher out of pocket cost.

Medication Name	Strength	Quantity Prescribed/ Day Supply		Prescribing Doctor	Phone
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		
			☐ Brand ☐ Generic		

Please describe the condition and/or treatment plan for which the member is requesting 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 _____