Permanente Advantage

Member Care Transition Form

Our goal is to make your transition of care as easy as possible. Please complete each section so we can best serve you. Once we receive your form, we will review the information and have a transition of care representative or nurse case manager contact you within five business days. We look forward to being your partner in health.

Note: Permanente Advantage provides medical review and case management for Kaiser Permanente Insurance Company (KPIC) Point-of-Service (POS), PPO and Out-of-Area (OOA) plans only.

SECTION 1

Employer name: _____ _____ Date of coverage: ____ / ____ / _____

Member's last name: _____ Member's first name: _____

Date of birth: ____ / ____ / _____ Health record no.: _____ Gender: ☐M ☐F

Relationship to employee: ☐Self ☐Spouse/Domestic Partner ☐Child/Dependent

Address: _____

Phone number: _____ Best time to call: _____

SECTION 2

Please tell us about your health care needs by answering the following questions.

☐Yes ☐No Are you pregnant? (Due Date: ____ / ____ /____ Trimester: ☐ 1st ☐ 2nd ☐ 3rd)

If yes, is your pregnancy considered high risk (multiple births, gestational diabetes, etc.)? ☐Yes ☐No

☐Yes ☐No Are you scheduled for surgery or hospitalization? Scheduled date: : ____ / ____ /____

Type of surgery or procedure: _____

☐Yes ☐No Are you receiving chemotherapy, radiation therapy, cancer therapy, or dialysis treatment?

Type of treatment: _____

☐Yes ☐No Are you receiving treatment related to a recent major surgery?

Type of surgery or procedure: _____

☐Yes ☐No Are you receiving mental health treatment or substance abuse treatment?

☐Yes ☐No Are you currently using durable medical equipment (hospital bed, oxygen, etc.)?

☐Yes ☐No Are you currently being treated with specialty pharmacy drugs (for conditions such as Multiple Sclerosis, Organ Transplant, HIV, Hepatitis, Osteoporosis, Auto-Immune disease, etc.)?

Condition being treated: _____

SECTION 3

☐Yes ☐No Are you currently working with a physician or dedicated case manager for your condition(s)?

Physician or Case manager name: _____ Phone number: _____

Specialty: _____ Condition: _____

PRINT

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