HEALTH NET OF CALIFORNIA TRANSITION OF CARE ASSISTANCE REQUEST FORM

Member's Name: _____ Subscriber's Name:_____
Subscriber's ID # or Social Security #:_____ Member's Birth Date:_____
Health Plan #:_____ Please Check One: ❒HMO ❒POS/PPO ❒Seniority Plus
Member's Address:_____
Member's Telephone #: Work: (____)_____ Home: (____)_____
Preferred Tel. # to call from 8-5: (____)_____

From: Medical Group/Insurance Co: _____ Phone #: (____)_____
Primary Care Physician: _____ Phone #: (____)_____
To: Medical Group/Insurance Co: _____ Phone #: (____)_____
Primary Care Physician: _____ Phone #: (____)_____

Current Diagnosis: _____
Current Treatment(s):_____

Reason(s) for Requesting Assistance (Please Check All That Apply)

My Medical Need(s) Is/Are (Please Check all that Apply)

❒ Surgery
❒ Radiation
❒ OP Mental Health
❒ Pregnancy and Immediate post partum
❒ Care of Newborn
❒ Acute/Serious Chronic Condition
❒ Scheduled Surgery/Procedure
❒ Specialist(s):
❒ Surgical Follow up Care
❒ Chemotherapy
❒ Transplant
❒ Terminal Illness
❒ Scheduled Appointment: Date: _____

Name of Specialist(s): _____ Phone # (____)_____
Name of Specialist(s): _____ Phone # (____)_____
Name of Specialist(s): _____ Phone # (____)_____
Name of Specialist(s): _____ Phone # (____)_____
Date of Scheduled Appointment: _____ Authorization # if Avail: _____
Authorized By:_____

Other Special Needs/Comments: ***

_____
_____
_____
_____
_____
_____
_____
_____

Member Signature:_____ Date: _____

If filled out by other than the member:
Name of Requestor:_____ Relation to Member: _____
Phone No. (____)_____ Date: _____

Please Mail to: Health Net of California Transition of Care Unit
Health Services – 4th floor
P.O. Box 9103, Van Nuys, CA 91409
or Fax to: (866) 295-4780

*** Attach another page for other additional information as needed ***