New Member Transition of Care Form

Please assist us in making the transition into our health plan as smooth as possible. If this applies to you or any of your dependents under your plan, please complete and return to us. If you need clarification, please call Health Services at (800) 448-3585 option # 4 *Thanks!*

PART 1

Name: ____ ID# (if known): ______________
Last First Middle Initial

Address: __________________________ City: __________ Island:__________ Zip: _______
Street Apt#

Phone: ____________________ Date of Birth: ____/____/____ Male ☐ Female ☐
Month Day Year

PART 2

Please place an "x" next to any of the following medical conditions that you are currently receiving treatment. Write additional medical problems in the blank spaces.

X		X	
	Asthma		Lupus
	Cancer		Obesity
	Congestive Heart Failure		Organ Transplant
	Diabetes		Rheumatoid Arthritis
	Hemodialysis		
	High Cholesterol		
	Hypertension		

PART 3

For women: Are you pregnant? ☐ No ☐ Yes, I am ________ months pregnant

Any anticipated problems with delivery / baby? ☐ No ☐ Yes

PART 4

Do you have any planned surgical procedures or hospital admissions? ☐ No ☐ Yes – Please provide date and nature of procedure/admission as these may require a prior authorization.

Does your doctor prescribe any durable medical equipment (wheelchair, oxygen etc.) or self injectable medications for you?

☐ No ☐ Yes
If yes, please list:

Are you currently under the care of any specialists? ☐ No ☐ Yes If yes, please list name of provider(s) and reason:

Any other pertinent health information?

Print member name: ____________________________ Member signature ____________________________

Protected Health Information (PHI) will not be disclosed to other parties without your written authorization except those directly involved in your care or as required by law.

When form is completed please return by fax or mail to:

HMA
ATTN: Health Services
1600 West Broadway Rd, Suite 300
Tempe, AZ 85282
Fax: 1 (866) 293-9665