Health Net

Health Net of California Transition of Care Assistance Request Form

Member's Name: _____ Subscriber's Name:_____
Subscriber's ID #:_____ Member's Birth Date:_____
Health Plan #:_____
Please Check One: Commercial HMO_____ POS/PPO_____
Medicare Advantage HMO_____ PPO_____
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 ___Surgical Follow up Care
___Radiation ___Chemotherapy
___OP Mental Health ___Transplant
___Pregnancy and Immediate post partum
___Care of Newborn ___Terminal Illness
___ Acute/Serious Chronic Condition
___Scheduled Surgery/Procedure ___Scheduled Appointment: Date: _____
___Specialist(s):

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 ***

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