Transfer your care

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: *If you answer **NO** to **ALL** of the questions in sections 2 and 3, please do not submit this form. To find a physician, schedule your first appointment, get help signing up for **kp.org**, or to ask other questions, please contact the New Member Help Desk at 1-888-491-1124. If you answer **YES** to **ANY** of the questions in sections 2 and 3, please complete and submit this form.*

SECTION 1

Employer name: _____ Group no. _____

Employee name: _____ Effective date of coverage: ____/____/____

Member's last name: _____ Member's first name: _____ Gender: ☐ M ☐ F

Date of birth: ____/____/____ Health record no.: _____ Added Choice® member? ☐ Yes ☐ No

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?

☐Yes ☐No Are you receiving substance abuse treatment?

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

☐Yes ☐No Are you currently receiving regularly scheduled infusions or injections?

SECTION 3

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

Case manager name: _____ Phone number: _____

Specialty: _____ Condition: _____

Complete and return this form via fax or mail:
Fax: 503-735-2589
Email: newmember-helpdesk@kp.org
Address: New Member Help Desk
3175 NW Aloclek Dr.
Hillsboro, OR 97124

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