Please complete the Continuity of Care and Release of Protected Health Information (PHI) Forms & return to FHCP, Case Mgmt, Fax 386-615-4058 or mail to FHCP, Post Office Box 9910, Attn: Case Management, Daytona Bch, FL 32120

## CONTINUITY OF CARE REQUEST: (Prospective Member)

**DATE:_____**

*(Please print clearly)*

FHCP's goal is to make your transition to our health plan easy and to avoid any disruption in your care. Therefore, if you, or one of your dependents, have any of the following needs in your care, please complete the Continuity of Care and Release of PHI Forms so a Care Navigator from FHCP Case Management Department may contact you to facilitate your care.

a. Are you or a dependent seeing an out-of-FHCP-Network physician? Please include the physician's full name, specialty, address, phone & fax numbers.
b. Are you or a dependent receiving care at an out-of-FHCP-network hospital/facility? Please include the hospital/facility's name & address.
c. Do you or a dependent have a surgery or a procedure planned that was approved by your previous insurance carrier?
d. Do you or a dependent have Durable Medical Equipment (DME) that was approved by your previous insurance carrier (eg., CPAP machine, Insulin supplies, Oxygen, etc.)
e. Do you or a dependent receive Injections or Infusions that were approved by your previous insurance carrier (such as cancer therapies, blood disorders, HIV/AIDS, etc.)
f. Are you or a dependent on a medication that is not on FHCP's Drug Formulary (drug list)?

**PROSPECTIVE MEMBER INFORMATION:** *(Circle one)* **Subscriber or Dependent**

*(Please complete one request form for each Member needing care continuity help.)*

**NAME:_____**

**FHCP Member #:_____**(If available).

**DOB:_____ SEX:_____ PHONE #:_____**

**EMPLOYER:_____ EFFECTIVE DATE: _____**

**PLAN TYPE:** *(circle one)* **HMO POS TRIPLE OPTION**

**PRIOR INSURANCE CARRIER:_____**

**PRIOR CASE MANAGER:_____**

**Continue to next page please**

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**NAME:**_____

**FHCP Member #:**_____(If available).

**BRIEF NOTE ON NEEDS/CONCERNS:**
*(Please print clearly)*

a. Are you or a dependent seeing an out-of-FHCP-Network physician? Please include the physician's *full name*, specialty, address, phone & fax numbers._____
_____
_____

b. Are you or a dependent receiving care at an out-of-FHCP-network hospital/facility? Please include the hospital/facility's name & address._____
_____
_____

c. Do you or a dependent have a surgery or a procedure planned that was approved by your previous insurance carrier? Please *briefly* describe the approved surgery or procedure.
_____
_____
_____

d. Do you or a dependent have Durable Medical Equipment (DME) that was approved by your previous insurance carrier (eg., CPAP machine, Insulin supplies, Oxygen, etc.) Please *briefly* describe the DME used in your care. _____
_____
_____

e. Do you or a dependent receive Injections or Infusions that were approved by your previous insurance carrier (such as cancer treatment, blood disorders, HIV/AIDS, etc.) Please *briefly* describe the condition for which you receive Injections or Infusions.
_____
_____
_____

f. Are you or a dependent on a medication that is not on FHCP's Drug Formulary (drug list)? Please include medication name, dosage and prescribing physician's full name. _____
_____
_____

g. Do you or a dependent have any other special care needs that FHCP Case Management should be aware of to help you in the transition of your care to FHCP?_____
_____
_____

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

**FLORIDA HEALTH CARE PLANS ● P.O. BOX 9910 ● DAYTONA BEACH, FL 32120**

FHCP Medical Record #: _____ Birth Date: _____

Patient Name and Maiden Name: _____ Social Security # _____

Address: _____

Home Phone #: _____ Work #: _____ ☐ MAIL ☐ PICKUP

I hereby authorize to release my: ☐ Paper Record ☐ Verbal Information ☐ Electronic Information

By: _____

To: Relationship: Phone Number

| | |
|---|---|
| ☐ Myself | ☐ Family Member Name: |
| ☐ Family Member Name: | ☐ Facility / Hospital / Doctor: |
| ☐ Family Member Name: | ☐ Other: |

STREET ADDRESS CITY STATE ZIP CODE

Purpose for release: ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Patient Request ☐ Other _____

Please release the following information contained in my medical record regarding my care and treatment.

| | | |
|---|---|---|
| ☐ Office Visits<br>☐ Immunizations | ☐ Operative Reports<br>☐ Radiology Reports | ☐ Labs/Date drawn _____<br>☐ Other _____ |

Date(s) of Service: _____ **Pertinent information may be faxed for emergent need only.**

**If this Sensitive Information is checked, the patient must initial.**

| | | | |
|---|---|---|---|
| ☐ HIV/AIDS information _____ | ☐ Drug and Alcohol _____ | ☐ Psychiatric _____ | ☐ Other _____ |

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, and/or AIDS (Acquired Immunodeficiency Syndrome) information, any may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, or facsimile machine (fax) or any other FHCP approved means. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to an FHCP Medical Records Department. I understand that the revocation will not apply to information that has already been released as requested by this authorization. I understand that any disclosure of information carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits FHCP from making any further disclosure without the specific written authorization of the person to whom it pertains. I understand that FHCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization.**

**Release of PHI Expiration Date: (Must either circle or enter an "Expiration Date")**
☐ Upon Death Or Expiration Date / / Or ☐ one year from the date of signature

_____ _____
Signature of Patient or Legal Representative/Authorized Health Surrogate* Date

_____ _____
Witness Date

*****Legal Representative/Authorized health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.

**FEES FOR COPYING AND/OR REVIEWING OF FHCP ARE AVAILABLE UPON REQUEST. PLEASE ALLOW SUFFICIENT TIME FOR COPYING AND/OR SCHEDULING A REVIEW OF MEDICAL INFORMATION (72 HOUR MINIMUM PROCESSING TIME).**