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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