Member Care Transition Form

KAISER PERMANENTE®

Please keep a copy of this form for your records and fax a copy to 1-877-661-2747 or mail to:
Kaiser Permanente, New Member Transition of Care Program, 2828 Paa St., Suite 2055, Honolulu, HI 96819-9903

Thank you for choosing Kaiser Permanente. Our goal is to make your transition into Kaiser Permanente as easy and convenient as possible. Returning this completed form will help us transfer your prescription medications and arrange for future doctor appointments for you and your covered family members. **Your employer will not see any of the information you provide, if you fax or mail this form to us instead of your workplace.** You may receive a call from one of our service representatives, depending on how you respond below. If you would like an interpreter, please let us know your preferred language: _____.

Member's last name: _____ Member's first name: _____

Effective date: _____ Date of birth: _____ / _____ / _____ Gender: ◯ M ◯ F

Member ID # (if previous member): _____ Plan type: ◯ DHMO ◯ HMO ◯ Added Choice

Best phone number to call: _____ Best day/time to call: _____

I would like to choose Dr. _____
as my primary care physician (you can also visit **kp.org/searchdoctors** to see your options and choose your doctor).

Please check the appropriate boxes for you and any covered family members so we can begin transitioning care for the following needs:

Pregnancy ☐ You ☐ Spouse ☐ Child Baby's due date: _____ /_____ /_____
In order to arrange proper and prompt prenatal care, please let us know if anyone in your family is pregnant.

Specialty care ☐ You ☐ Spouse ☐ Child
To continue your specialty care at Kaiser Permanente, please tell us if you were seeing a specialist or receiving specialty care prior to enrolling.

Prescription medications ☐ You ☐ Spouse ☐ Child
Transferring your prescriptions will make it easier for you to refill medications from a Kaiser Permanente pharmacy.

Child or sports physical ☐ Check here so we may help schedule your child's next physical.

Please tell us about any other health care needs you have (for example, hospital bed, social worker, case manager, oxygen, ostomy supplies, CPAP, etc.)

_____

_____

_____

FOR KAISER PERMANENTE INTERNAL USE ONLY: MRN: _____ **Effective date:** _____
Group name: _____ **Group #:** _____ **Subgroup #:** _____

Kaiser Permanente is committed to protecting the privacy and confidentiality of your health information. Use and disclosure of health information on this form is voluntary and intended to provide ongoing transition of care to the individual. Our use and disclosure of an individual's personal information (including health information) is limited as required by state and federal law. As part of the Health Insurance Portability and Accountability (HIPAA), Kaiser Permanente provides you, our members, and patients, with a notice about your privacy rights and Kaiser Permanente's privacy practices. The notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. Go to **kp.org/privacy** to view our Notice of Privacy Practices.

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