Regence BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Coordination of Care Form for Selections® Plus

Providing the information requested below for each person covered under the Selections Plus plan will help our healthcare professionals better coordinate your care, especially for those with ongoing or complicated medical conditions. For example, you may be pregnant or undergoing treatment for cancer. Completion of this form authorizes Regence BlueShield to contact your physician to coordinate care.

Date:________________________

Member's Name:____ Selections®Plus ID Number:____________________________

Member's Date of Birth:___________________________________

Address:____City/State/ZIP: ____

Phone Number: Home ( )________________________________ Work ( )__________________________________

Does the member need or has the member received medical care for the following conditions? Please check all that apply:

- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer
- ☐ Depression
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Kidney Failure
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Morbid Obesity
- ☐ Stroke
- ☐ Pancreatitis/Liver Failure
- ☐ Immunologic Disease
- ☐ Premature Delivery
- ☐ Peripheral Vascular Disease
- ☐ COPD/Emphysema/Chronic Bronchitis
- ☐ Ulcerative Colitis/Crohn's Disease
- ☐ Currently pregnant
- ☐ Other___________________________

Has the member needed the following services or equipment in the past year? Please mark all that apply:

- ☐ Hospitalized
- ☐ Two or more Emergency Room Visits
- ☐ Home Health Services
- ☐ Skilled or Unskilled Hourly Care Services
- ☐ Rehabilitative Services
- ☐ Skilled Nursing Facility Care
- ☐ Infusion Therapy
- ☐ Wheelchair

Name of your primary physician:______________________ Phone Number ( )____

If under the continuous care of a specialist, the names and specialties of your providers:

Physician:____Phone Number ( )____

Physician:____Phone Number ( )____

Physician:____Phone Number ( )____

☐ Does the member have surgery scheduled? If yes, date of proposed surgery:_______________________________________

Type of surgery:____

Surgeon's name:____Phone Number: ( )________________

☐ A case manager has been involved in the care from the previous health plan.

Name of health plan: ____

Name of Case Manager:____Phone Number ( )_________________________

☐ Currently taking medications? If yes, please list names of medications:____

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