TRANSITION OF CARE FORM

To ensure your medical care continues uninterrupted until you are seen and established with your new Western Health Advantage Primary Care Physician (PCP), please complete the following questionnaire.
Completion of this questionnaire is only required if you are under current medical treatment and care for a specific medical condition. Once you have completed the questionnaire, please return it to the address listed below. This will allow Western Health Advantage to alert your current healthcare insurance carrier and treating physician(s) to transfer any necessary medical information to Western Health Advantage. This will allow Western Health Advantage to ensure your care and treatment continues without interruption or fragmentation.

Name:____ **Date of Birth:**____ /____ /_____

Social Security #:______ /_____ /________ **Home Phone #:**______ /______-___________

Address: ________________________________ **Employer:** ________________________

City: ______________________ **Zip:**____________ **Work Phone#:**_____ /______-__________

WHA Medical Group of Choice (this can be changed):______________________________

WHA PCP of Choice (this can be changed): ______________________________________

Current Health Plan: _______________________ **Current PCP:**______________________

Current Treating Physician: ____________________________ **Specialty:** ______________

Condition Being Treated: ________________________________ **Initial Date:** ____________

Treatment:____

If Pregnant, Due Date: _________________ **Scheduled Hospital:** ______________________

Comments: ____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named physician, hospital and/or other healthcare provider(s) and my current health care plan ______________________________, to furnish any and all records pertinent to my current medical condition to Western Health Advantage.
Please submit all records to :

WESTERN HEALTH ADVANTAGE
Attention: MEMBER SERVICES/ENROLLMENT
1331 GARDEN HIGHWAY, SUITE 100
SACRAMENTO, CA 95833
1-888-2-ASK-WHA (1-888-227-5942)

A photostatic copy of this authorization shall be considered as valid as the original.

Members
Signature:____ **Date:**________________