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 NUMBER:_____ /____ /_____PHONE #:____ /____-_____

ADDRESS:_____

CITY:_____ZIP:_____PHONE#:____ /_____-_____

WHA GROUP OF CHOICE (this can be changed):_____

CURRENT HEALTHPLAN:_____

CURRENT PCP:_____& TREATING PHYSICIAN:_____

DATE OF INITIAL DIAGNOSIS/TREATMENT:_____

CONDITION BEING TREATED:_____

IF PREGNANT, DUE DATE:_____

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:_____