Health Information Form

Partnership will use this form to make sure you get the care that you may need.

Please circle each answer that applies to you. Complete one form for each person in your family who is newly assigned to Partnership.

If you have questions, please call Partnership at: **(800) 863-4155** Monday through Friday, between 8 a.m. - 5 p.m. TDD users should dial: (800) 735-2929.

Please mail this completed form to:
Q&A Research Inc
#357, 22052 W 66th Street
Shawnee KAS 66226-9905

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Name of Partnership Member:______________________________

Date of Birth: ____________________ **Medi-Cal ID Number:**____________________

1. Do you need to see a doctor within the next 60 days?	YES	NO
2. Do you take 3 or more prescription medications each day?	YES	NO
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia?	YES	NO
4. Have you been to the emergency room two (2) or more times in the last twelve (12) months?	YES	NO
5. Have you been admitted to the hospital in the last twelve (12) months?	YES	NO
6. Have you needed help with personal care such as bathing, getting dressed, or changing bandages in the last six (6) months?	YES	NO
7. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen or ostomy bags?	YES	NO
8. Do you have a condition that limits your activities or what you can do?	YES	NO
9. Are you pregnant?	YES	NO
9a. *If yes, are you currently seeing a doctor for this pregnancy*?	YES	NO
10. Do you see a doctor for a chronic medical condition?	YES	NO

If yes, circle all that apply:

a. Asthma / Lung Problems	b. Heart Problems	c. Diabetes
d. HIV or AIDS	e. Kidney Disease	f. Seizures

g. Other ______________________________

These answers will be sent to PHC. If you think you need to see a doctor before PHC contacts you, you should go to the doctor or hospital at that time.

Please note, if you change to another health plan and we get a request, PHC will share this health information form with your new plan.

Signature of Person
Filling Out the Form:______________________________ Date Signed: ____________________

If not signed by beneficiary, specify relationship: Parent/ Guardian Other Representative

CONFIDENTIAL