**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**
**Missed Appointment Notification Form**

Providers fax this form to Partnership's Member Services Department (707) 863-4415 attention: Enrollment Unit

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|---|---|
| Patient Name: | Date of Birth (MM/DD/YYYY): |
| Parent/Guardian Name (if applicable): | Phone Number: |
| Primary Diagnosis: | Partnership ID# (on the Partnership ID Card): |
| Dates of missed appointments within the last 3 months: | Dates of the last kept appointments: |
| If your request is from a specialist, PCP office has been notified of missed appointments ☐ Yes ☐ No | |
| Was the patient notified or reminded of appointment date and time: ☐ Yes ☐ No<br><br>When was the patient notified or reminded of the last scheduled appointment? _____<br>(date)<br>How was the patient notified/reminded of the last scheduled appointment?<br>☐ at the physician's office ☐ over the phone ☐ by mail ☐ by email | |
| List interventions done when member missed appointments: | |
| What was the member's response to your interventions? | |
| Name of Provider: | |
| <u>Person completing form</u><br>Name:<br><br>Date form was completed: | Phone:<br><br>Fax: |

| **Partnership USE ONLY** |
|---|
| Member was contacted by phone on (date): |
| Letter was sent to member on (date): |
| Reasons for missing appointments: |
| Comments: |

Form #29

Care Coordination Referral: _____
CC: Provider Relations: _____