Transitioning Care to Sentara Health Plans

Thank you for choosing Sentara Health Plans for your health coverage! By giving us information about your health conditions and medications, we will be able to aid in your continuity of care and ensure a smooth transition to your new health plan.

This screening will take approximately five minutes to complete.

Completion of the screening is voluntary. You will not be denied health plan coverage or treatment under your new plan if you do not complete the screening. If you are completing this form for multiple family members, please complete a form for each family member.

If you would like to download, print, and complete, surveys can be mailed or faxed to:

Sentara Health Plans
Attn: Commercial Case Management
PO Box 66189
Virginia Beach, VA 23466
Fax Number (757) 822-6201

i. ****Required** Please provide your FULL government name and date of birth:**

_____

First Name *Middle Initial* *Last Name* *Date of Birth*

ii. **Please provide the best phone number, email address, and mailing address to contact you.**

Phone Number	
Email Address	
Mailing Address	

iii. ****Required**** Please provide the name and contact information for each physician and provider that treats you:

Provider's Name	Provider's Address	Provider's Phone Number

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Appointments…	No	Yes
Do you have an upcoming appointment with any of your healthcare providers?	☐	☐
Prescriptions…	**No**	**Yes**
Do you expect to have any prescriptions filled or refilled within 30 days of new enrollment?	☐	☐
Medical Equipment…	**No**	**Yes**
Do you use medical equipment for mobility and/or for use in day-to-day tasks?	☐	☐
A) Do you anticipate needing to receive any medical equipment within 30 days of new enrollment?	☐	☐
B) If you selected yes above, select the type of medical equipment needed:	☐Oxygen ☐Diabetes supplies ☐CPAP ☐Other	

iv. ****Required**** Have you ever been diagnosed with any of the following conditions?

Condition	No	Yes
Asthma	☐	☐
Heart Disease (Coronary Artery Disease, Angina, Heart Attack, A Fib)	☐	☐
Chronic Obstructive Pulmonary Disease (COPD)	☐	☐
Emphysema or Chronic Bronchitis	☐	☐
Heart Failure (CHF)	☐	☐
High Blood Pressure or Hypertension	☐	☐
End Stage Renal Disease	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Depression, Anxiety, or other Behavioral Health diagnoses	☐	☐
Osteoporosis	☐	☐
Cancer	☐	☐
Alzheimer's or Dementia	☐	☐

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v. Have you experienced any of the following in the last two weeks?

Mood…	No	Yes
Little interest or pleasure in doing things	☐	☐
Feeling down, depressed, or hopeless	☐	☐

vi. Are you currently seeing a behavioral healthcare provider?

No	Yes	Provider's Name
☐	☐	

vii. Describe your general overall health: *(Check only one)*

Excellent	Good	Fair	Poor
☐	☐	☐	☐

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****Required**** **Authorization**

As a new Sentara Health Plans enrollee, I understand that Sentara Health Plans would like to collect some limited information about my health conditions and medications prior to the start of my new health plan coverage.

I authorize Sentara Health Plans to share the information collected about my health or the health of my dependents with Case Management teams, my assigned Sentara Health Plans physician, and the Sentara Health Plans pharmacy team to assist with continuity of care under my new health plan.

I understand that my health information will be entered into a secured medical record.

Any information received by Sentara Health Plans is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that I or my authorized legal representative may receive a copy of this Authorization upon request, and I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that this Authorization is valid for three (3) months from the data shown.

_____

Signature of Applicant or *print and sign name of Legal Representative* *(mm/dd/yyyy)*

Thank you for completing this survey! If you would like to talk to one of our Case Managers about your care, please contact us at: 1-866-503-2730.