Florida Health Care Plans

An Independent Licensee of the Blue Cross and Blue Shield Association

Please complete the Continuity of Care and Release of Protected Health Information (PHI) Forms & return to FHCP Attn: Transition of Care: Fax 386-676-7149, e-mail to toc@fhcp.com or mail to: FHCP Member Services Department, Post Office Box 9910, Daytona Beach, FL 32120. If you have any questions about this form, please call (386)615-5017 Monday- Friday 8am-5pm, TTY Relay 711.

Member Name: **DOB:** **Sex:**

Address:

Phone #:

Emergency Contact Info:

Primary Care Provider (Name & Phone#):

1) Are you under the care of a Specialist? ☐ **Yes or** ☐ **No**

Name of Provider(s), Provider's Specialty, Phone Number and Reason for Care:

2) Are you currently receiving Radiation or Chemotherapy? ☐ **Yes or** ☐ **No**

Name of Provider(s), Provider's Specialty, Phone Number and Reason for Care:

3) Do you have any upcoming appointments for tests or procedures scheduled on or after you become effective with our plan? ☐ **Yes or** ☐ **No**

Appointment Date: Test/Procedure Type:

Provider Name (or Facility Name) and Phone #:

Appointment Date: Test/Procedure Type:

Provider Name (or Facility Name) and Phone #:

4) Are you currently on any medications? ☐ **Yes or** ☐ **No**

Name of Medication, Strength and Dosage:

5) Do you use any rented Durable Medical Equipment (oxygen, wheelchair, etc.)? ☐ **Yes or** ☐ **No**

Please list the equipment you have and the Provider who supplied it, as well as their phone #:

6) Do you use any medical supplies (diabetic, wound care, ostomy, etc.)? ☐ **Yes or** ☐ **No**

Name of Provider(s), Phone Number and Type of Supplies Received:

ADDITIONAL INFORMATION/COMMENTS:

Release of Protected Health Information (PHI) Forms completed? ☐ **Yes or** ☐ **No**

COMPLETED BY: **DATE:**