AETNA BETTER HEALTH®

Transition of care form

Please complete this form and return it in the envelope provided.

Member name ____Member ID #__________________________

Your name (if you are not the member) __________________________Member date of birth ___________________

Address____Phone number (___)________________ __

Current Care

1. Have you chosen a new doctor? ☐ Yes ☐ No

If yes, doctor's name____ Phone number (___)____________________________

2. Have you scheduled an appointment with your new doctor? ☐ Yes ☐ No

3. What other doctors do you see?

Doctor's name____ Phone number (___)________ ___________________

See this doctor for____

Doctor's name____ Phone number (___)________ ___________________

See this doctor for____

4. Are you pregnant or have you had a baby in the last 30 days? ☐ Yes ☐ No

If yes, when are you due? When did you deliver? Date ____________________________________

5. Do you have a doctor for this pregnancy? ☐ Yes ☐ No

Doctor's name____ Phone number (___)________ ___________________

6. Are you currently getting home health services? ☐ Yes ☐ No

7. Are you currently using durable medical equipment (like a wheelchair, oxygen or breathing machine)? ☐ Yes ☐ No

8. Are you scheduled for or receiving any of the following:

☐ Elective surgery
☐ Rehabilitation therapy
☐ Substance abuse treatment
☐ Dialysis
☐ Physical, speech or occupational therapy
☐ Cancer treatment
☐ Mental health treatment
☐ Other ____

Medications

1. Are you currently taking medications or using any injectable medication(s), other than insulin? ☐ Yes ☐ No

2. Do you think you will have a problem getting any prescription filled over the next 90 days? ☐ Yes ☐ No

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CONTINUED ON REVERSE

Health Information History

1. Have you been treated in the emergency room in the past six months? How many times? ________________

2. Have you been in the hospital in the past six months? How many times? _____________________________

3. Have you been told you have any of the following? Please check all that apply.

☐ Asthma
☐ Diabetes
☐ Chronic obstructive pulmonary disease (COPD)
☐ Congestive heart failure (CHF)
☐ Coronary artery disease (CAD)
☐ Substance abuse needs
☐ HIV / AIDS
☐ Mental health needs
☐ Cancer Type____ Date _____________________
☐ Organ transplant Type____ Date _____________________
☐ Other ____

4. Are you or a dependent enrolled in special programs? Check all that apply.

☐ Alzheimer's Assisted Living (AAL) Waiver
☐ Day Support Waiver
☐ Elderly or Disabled with Consumer Direction (EDCD) Waiver
☐ HIV/AIDS Waiver
☐ Individual and Family Developmental Disabilities Supports (IFDDS) Waiver
☐ Intellectual Disabilities/Mental Retardation (ID/MR) Waiver
☐ Technology Assisted (Tech) Waiver

5. Are you having problems getting care with any services? ☐ Yes ☐ No

6. Do you have any concerns where you may need help from a case manager or a counselor? ☐ Yes ☐ No

If yes, what is the best way to reach you? ____

7. What is your language preference? ☐ English ☐ Spanish ☐ Other Language _________________________

☐ Other communication needs ____

Do you speak and understand English well? ☐ Yes ☐ No

Please complete and return in the addressed envelope to:

Aetna Better Health
One South Wacker Drive, 12th Floor, Mail Stop F646, Chicago, IL 60606
Questions? Call toll-free **1-866-212-2851** or visit www.aetnabetterhealth.com/illinois

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