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 ☐ Physical, speech or occupational therapy

☐ Rehabilitation therapy ☐ Cancer treatment

☐ Substance abuse treatment ☐ Mental health treatment

☐ Dialysis ☐ 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

☐ Chronic obstructive pulmonary disease (COPD)

☐ Coronary artery disease (CAD)

☐ HIV / AIDS

☐ Diabetes

☐ Congestive heart failure (CHF)

☐ Substance abuse needs

☐ 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 **1-866-600-2139** or visit www.aetnabetterhealth.com/
illinois

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