Verda Health Plan of Texas

Coordination of Care Form

Member Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Date of Birth: _____ Phone: _____

Emergency Contact: _____ Phone Number _____ Relationship _____

Preferred Spoken Language: ☐ English ☐ Spanish ☐ Cantonese ☐ Korean ☐ Mandarin ☐ Tagalog ☐ Vietnamese ☐ Other

Primary Care Physician / Medical Group Information

PCP with Verda Healthcare _____

Same PCP prior enrolling to Verda? YES ☐ NO ☐

Medical Group / IPA with Verda Healthcare _____

Same Medical Group / IPA prior enrolling to Verda? YES ☐ NO ☐

If No, who is the current PCP and Medical Group? _____

Continuity Of Care and Services

Please let us know if you have any of the following issues that apply to you, we will have a Care Coordination Team member contact you to assist with the transition of services:

☐ Immediate Needs – Food, Homeless, Cannot Afford Medications

☐ Middle of Treatment – Chemotherapy / Dialysis / Home Health

☐ Currently Hospitalized

☐ Planned Surgery in the coming months

☐ Durable Medical Equipment – ☐ Own ☐ Rental

If **Rental, who is** the DME Company?
Name: _____ Phone: _____

☐ Bath Chair ☐ Commode ☐ Hospital Bed ☐ Toilet seats
☐ Cane ☐ CPAP machine ☐ Oxygen ☐ Walker
☐ Catheters ☐ Diapers ☐ Pressure Mattress ☐ Wheelchair
☐ Other _____
☐ Other _____

Medications

Please provide a list of medications that require Prior Authorization or not on our formulary, our Care Coordination Team member will contact you to assist with the prescription transition fills:

Medication Name: _____ Dosage: _____

Medication Name _____ Dosage: _____

Medication Name _____ Dosage: _____