Advanced Health
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HepC Care Management Notification Form

Provider Information:

Provider Submitting Form: ___________________________ Provider Phone #: ___________________________

Patient Information:

Patient Name: _____________________________________ Date of Birth: _____/_____/_____

Address: ____ Phone #: __________________________________

Additional Information:

Is the patient on Advanced Health: YES NO If Yes, enter Advanced Health/OHP#:_________________

Has patient previously been treated for HepC? YES NO

If Yes, what treatment did they receive? ____

Did they complete the treatment? YES NO

If No, please provide information detailing why treatment was not completed (eg. medication side effects, non-adherence, etc.) ____

____

Does patient have GI/Hepatology/Infectious Disease Specialist? (check one): YES NO

If Yes, who? ____

Waiver of Information:

Patient must sign the release of information below.

I understand that this form will be forwarded to Advanced Health, my Oregon Health Plan Coordinated Care Organization. The information provided will be used to contact me so that I may be enrolled in HepC Care Management and receive information regarding available health care services.

Patient signature: ____ Date: _____/_____/_____

Contact Kristien Van Elsberg @ 541-266-6504 or @ kristien.vanelsberg@advancedhealth.com