Martin's Point

US FAMILY HEALTH PLAN

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Your health is our top priority. To prevent coverage gaps during your transition to your Martin's Point US Family Health plan, **please complete this form or have your provider complete it for you**. The US Family Health Plan will honor referrals from other TRICARE-authorized providers when beneficiaries move geographical regions within the service area from a different TRICARE Prime or TRICARE Select plan.

Note: Please attach any existing approved referrals or authorizations from your previous health plan to facilitate processing.

Patient Name (last, first, middle):	Patient Date of Birth:	
Home Address:	City:	State:
Zip Code	Phone Number:	

Check all that apply:

1. Does the patient have established care with a specialist in the USFHP Service area?
   Yes ☐ No ☐
2. Is the patient currently pregnant?
   Yes ☐ No ☐
3. If pregnant, is the pregnancy considered high-risk?
   Yes ☐ No ☐
4. Is the patient scheduled for surgery or inpatient hospitalization?
   Yes ☐ No ☐
5. Is the patient receiving any sort of treatment, such as physical or occupational therapy, radiation therapy, chemotherapy or enteral nutrition therapy?
   Yes ☐ No ☐
6. Is the patient receiving mental health or substance abuse care?
   Yes ☐ No ☐
7. Is the patient currently renting durable medical equipment from a provider (ex. oxygen, CPAP, insulin pump, continuous glucose monitor (CGM), ostomy or catheter supplies)?
   Yes ☐ No ☐
8. Are you or any of your family members currently enrolled in the EFMP (Exceptional Family Member Program) or the ECHO program?
   Yes ☐ No ☐

Please provider the name, address, and phone number of any specialist in which you are currently receiving care in the US Family Health Plan's service area or via telehealth.

Provider #1 Hospitalization/Procedure/Appointment Date: ____/____/____
Date you began seeing this provider for this course of treatment: ____/____/____

Provider Name:

_____

Provider Address:

_____

Provider Phone #:

_____

Provider Fax
#:_____

_

Reason for Visit:

_____

Is provider out of network? □ Yes □ No □ Unsure

Provider #2 Hospitalization/Procedure/Appointment Date: ____/____/_____

Date you began seeing this provider for this course of treatment: ____/____/____

Provider Name:

_____

Provider Address:

_____

Provider Phone #:

_____

Reason for Visit:

_____

Is provider out of network? □ Yes □ No □ Unsure

Care Management Questions

Were you working with a nurse or social work care manager with your previous health plan? □ Yes □ No

If yes, what health care needs were being addressed?

_____

Would you like to be contacted by the Care Management Department at Martin's Point Health Care to discuss your health care needs? □ Yes □ No

I authorize Martin's Point Health Care to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: □ Home □ Cell □ Do not leave confidential information on my voicemail

Patient or Guardians Signature_____

Returning Your Form

Please use the enclosed envelope to return this form by mail to:

Health Management Department, Martin's Point Health Care, PO Box 9746, Portland, ME 04104

Have Questions? Need Assistance?

If you have any questions or need assistance completing this form, call the Member Services number on the back of your member ID card.