CoxHealth
Medicare Advantage
by Cox HealthPlans

PO Box 5750
Springfield, MO 65801-5750
CoxHealthMedicareAdvantage.com

Care Coordination Form

CoxHealth Medicare Advantage (HMO) would like to assess and help coordinate your care as you transition onto our plan. Please fill out this form and include any course of treatment you are currently undergoing and the providers you are seeing. Examples of "course of treatment" may include but are not limited to diabetes, chronic pain, complex wound care, chemotherapy, or radiation therapy.

Please send this form to us via mail, addressed to CoxHealth Medicare Advantage Medical Department. We look forward to helping you!

Your First/Last Name:_____ **Date of Birth**_____/_____/_____

MBI: _____

Most convenient way to reach you by phone between 8:00AM – 5:00PM:

Home:_____ **Cell:**_____ **Work:** _____

E-Mail: _____

Do you have a Primary Care Provider? If so, please provider their information.

Your Primary Care Provider (First, Middle, Last Name):_____

Location:_____ **Phone:**_____

Pharmacy:_____ **Location:**_____

Do you see a Specialist? If so, please provide their information.

Your Specialist (First, Middle, Last Name):_____

Location:_____ **Phone:**_____

Pharmacy:_____ **Location:**_____

Please list any conditions you are currently in active treatment for:

_____

_____