HEALTH NET FEDERAL SERVICES, LLC
MEDICAL MANAGEMENT NOMINATION FORM

CASE MANAGEMENT FAX: 888-965-8438
DISEASE MANAGEMENT FAX: 888-965-8823

THIS STATEMENT APPLIES ONLY TO REFERRALS REQUESTED BY BENEFICIARIES:
This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy, security rules and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from individuals necessary for their enrollment in TRICARE programs including managing enrollment through Web-based tools, assisting individuals in obtaining authorizations, eligibility determinations, health care provider referrals, customer services, facilitating medical management, provider services and payment activities.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may be specifically disclosed outside the Department of Defense as a routine use under 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services and Homeland Security, and to other federal, state, local and foreign government agencies, private business entities under contract with the Department of Defense, and individual providers of care on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

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Select a program. You may choose more than one:

☐ Case Management Behavior Health	☐ Disease Management Diabetes
☐ Case Management Physical Health	☐ Disease Management Heart Failure
☐ Children with Special Healthcare Needs	☐ ECHO
☐ Disease Management Anxiety	☐ End of Life
☐ Disease Management Asthma	☐ Maternity Management
☐ Disease Management Chronic Obstructive Pulmonary Disease (COPD)	☐ Neonatal Care Management
☐ Disease Management Coronary Artery Disease (CAD)	☐ Transplant
☐ Disease Management Depression	☐ Warrior Care Support

Date referred:	Referred by:	Phone: ( )	Fax: ( )

Services Requested For:

Name:		Sex: ☐ M ☐ F	D.O.B.
Street address:	City:	State:	ZIP:
Home phone: ( )	Work phone: ( )		
MTF:		MTF contact:	

Military Sponsor Information

Name:	ID #:	Work phone: ( )	Home phone: ( )	
Address:	City:	State:	ZIP:	

Insurance Information

TRICARE plan *(Select One):* **Other** Other:	Do you have other health insurance?	Insurance plan:
Status *(Select One):* **Active Duty Family Member**	☐ Yes ☐ No	

Medical Provider Information

☐ Primary Care Manager (PCM)	☐ Specialist	☐ Other
Name:	Name:	Name:
Address:	Address:	Address:
Phone: ( )	Phone: ( )	Phone: ( )
Pager: ( )	Pager: ( )	Pager: ( )
Specialty:	Specialty:	Specialty:

Reason For Referral