PacificSource Community Health Plans
2965 NE Conners Avenue, Bend OR 97701
541-385-5315 888-863-3637
Medicare.PacificSource.com

Care Access and Handoff Request

A provider or facility you use is leaving our network. Even though their contract is ending, we want to be sure your care continues without problems. Please fill out the attached Care Access and Handoff Request Form so we can:

1. **Check if you qualify to keep seeing this provider**—for example, if you are pregnant, being treated for a serious illness, or healing from surgery.
2. **Approve more visits at your in-network benefit level** for a short time (up to 90 days, or longer in some cases) while you finish treatment or move to another provider.
3. **Assign someone (nurse case manager or care navigator) to help** with medical records, making appointments, transportation, and support during the change.

What you need to do:

- Fill out **Sections A–D** on the next page with your treatment details.
- Sign **Section F** and make sure the form is complete. Missing information may slow things down.
- Return the form **within 90 days** of the date on the provider termination notice we sent you.
- Send the completed form to by secure portal upload (InTouch), fax, or mail (instructions are on the next page).

Questions?

Chat with us through our secure member portal, InTouch for Members. Sign in or create your account at **Medicare.PacificSource.com/InTouch**. Then, click the chat icon in the lower right corner for help from our Customer Service team.

You can also reach us by phone at **888-863-3637**, TTY: 711. We accept all relay calls. We are open:

- **October 1 to March 31:** 8:00 a.m. to 8:00 p.m. local time, seven days a week.
- **April 1 to September 30:** 8:00 a.m. to 8:00 p.m. local time, Monday – Friday.

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Care Access and Handoff Form

PacificSource Medicare

Section A – Member Information

Member name _____ Member ID _____

Date of birth (MM/DD/YYYY) _____ Phone _____

Email _____

Primary address _____

City _____ State _____ Zip _____

Section B – Terminating Provider Information

Provider/Facility name _____

Specialty _____ Phone _____

Address _____

City _____ State _____ Zip _____

Section C – Reason for Care Access and Handoff Request

- ☐ Pregnancy (due date: _____)
- ☐ Serious & complex condition (such as chemotherapy, radiation)
- ☐ Terminal illness (expected to live less than 6 months)
- ☐ Ongoing inpatient or institutional care
- ☐ Required surgery scheduled (Date: _____)
- ☐ Follow-up care for a recent surgery (Date: _____)
- ☐ Organ or bone-marrow transplant (Which type: _____)
- ☐ Behavioral health / substance-use disorder treatment (last visit within last 45 days)
- ☐ Continue to see primary care provider (120-day grace)

Section D – Treatment Details

Health issue being treated _____ Date treatment began _____

Planned end date _____ Current/planned services _____

Authorization number (if any) _____ Number of visits requested _____

Section E – Preferred Contact Method

☐ Phone ☐ Email ☐ InTouch Message

Section F – Signatures

Member/Legal guardian signature _____ **Date** _____

Treating Provider signature (optional) _____ **Date** _____

Return completed form one of these ways: **InTouch upload:** PacificSource.com/login

Fax: 541-385-3123 **Mail:** PacificSource Medicare, Attn: Care Access Request, PO Box 7068, Springfield, OR 97475