



Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company
Ongoing Care Assistance Request

To be completed by Health Net member

Patient Name: _____ Date of Birth: _____

Relationship to Employee: Self Spouse Child Other _____

Employee Name: _____ Member ID: _____

Employee Address: _____ City: _____ State: _____ Zip: _____

Work Phone: () - _____ Home Phone: () - _____

Plan Selection: PPO HMO Triple Option Other _____

Current Primary Care Provider (PCP): _____ Phone: () - _____

Current Specialist: _____ Phone: () - _____

Nature of Ongoing Care: _____

For prenatal care, what is the expected delivery date? _____

Selected Primary Care Provider (PCP): _____ Phone: () - _____

Disclaimer: All services must be coordinated and authorized through your Health Net Primary Care Provider for HMO and POS plans.

Please note that this request form is not a guarantee of coverage or payment for health care benefits. Health care benefits will be paid according to your plan contract.