

Health Information

ONE MEMBER PER FORM



Please take a few minutes to fill out this form. This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail. You may also fill this form out online at SilverSummitHealthPlan.com.

If you have any questions, call SilverSummit Healthplan at 1-844-366-2880 (TDD/TTY: 1-844-804-6086).

One Member per form

Member Name (Last,First):

Date of Birth (MM/DD/YYYY):

*Medicaid ID:

Name of person answering questions:

Relationship to Member:

- Parent Guardian Spouse Friend Lawyer Provider Other

If we would need to return a call to you, what is the best time to reach you?

- Morning Afternoon Evening

What is the best telephone number to reach you?

Member's Height: Feet Inches Member's Weight: Pounds

Do you know who your PCP (doctor) is? Yes No

Do you have an appointment scheduled with your PCP? Yes No

Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them? Yes No

Have you been admitted to a hospital in the last 12 months? Yes No

Have you been to the emergency room (ER) more than once in the last six months? Yes No

Are you currently pregnant? Yes No Unsure N/A

Do you currently have any of the following conditions? (check all that apply)

- Alcohol or Substance Abuse Asthma Cancer COPD
 Depression Diabetes Heart Disease High Blood Pressure
 HIV/AIDS Kidney Disease Mental Health Condition
 Transplant (On waiting list or received transplant in the last 12 months) Tobacco use

Other medical condition(s)

Do you have any special needs (such as hearing, vision or mobility problems)? Yes No

If yes, please describe special needs



Health Information p. 2

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Name:

Date of Birth (MM/DD/YYYY):

*Medicaid ID:

*Are you eligible to receive Indian Health Services? Yes No

Are you eligible for Home Community Based Services or Waiver services? Yes No

