GPA HEALTHWATCH

Group & Pension Administrators

Park Central 8, 12770 Merit Dr. Suite 200, Dallas, Texas 75251 • 800-827-7223 • https://www.gpatpa.com/healthwatch.php

TRANSITION OF CARE REQUEST FORM

Utilize this form to provide notification to GPA HealthWatch for any members with ongoing care such as scheduled procedures or needing assistance from a case manager during time of transition to new health plan. Please complete this form and the Medical Release Form completely and submit to toc@gpatpa.com.

Employee Information			
Name (first, last)			
Employer Group Name			
Other ID Number		Date of Birth	
Patient Information			
Name (first, last)			
Other ID Number		Date of Birth	
Phone Number		Best Time to Call	
Email		Preferred Method of Contact	
Treating Provider			
Name (first, last)			
Address			
Phone Number			
Next Scheduled Appointment			
Treating Provider			
Name (first, last)			
Address			
Phone Number			
Next Scheduled Appointment			
Treating Provider			
Name (first, last)			
Address			
Phone Number			
Next Scheduled Appointment			
Facility			
Name			
Address			
Phone Number:			
Current diagnoses:			
Scheduled and planned procedures:			
Current prescription medications and over-the-counter medications:			
Please tell us why you want help with your current medical care. Please include details and other special needs or comments:			

Submit this form to toc@gpatpa.com

GPA HealthWatch will review your request and health plan for Transition of Care. If you have questions, please contact Diana Castro, Supervisor, Benefit Review at 972-744-2342 or Randall Johnson, HealthWatch Manager at 972-744-2333.

HEALTHWATCH

Group & Pension Administrators

Park Central 8, 12770 Merit Dr. Suite 200, Dallas, Texas 75251 • 800-827-7223 • https://www.gpatpa.com/healthwatch.php

MEDICAL RELEASE FORM

Patient Name: _____

Cardholder Name: _____

Employer: _____

Date: _____

HealthWatch is the Utilization Review, Case Management, and Disease Management Department for Group & Pension Administrators. In order to effectively assist you in your health improvement efforts, I will need information regarding your medical history.

Medical Release

I hereby give my authorization for the release both verbally and in writing, of my medical records, to include treatment diagnoses, diagnostic records, laboratory results, and other information in my health record to GPA HealthWatch. I understand that GPA HealthWatch will use these records to assess program needs as it relates to my health and I understand that GPA HealthWatch may send these records to physicians or other Health Care providers for review as it relates to the notification or case management process.

By signing this release, I consent to enrollment in the HealthWatch Care Coordination program.

Signature of Patient/Guardian: _____Date: _____

This release is in effect for one year following the date of your signature and applies to:

- All current treating physicians and specialists (medical and/or mental)
- Family members as listed: _____

Please complete the following information:

Your Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City, State & Zip: _____ Cell Phone: _____

Email address: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Number: _____

Submit this form to toc@gpatpa.com

With respect to the HIPAA Privacy Rule, a permissible use or disclosure of Protected Health Information is for Treatment, Payment, or Healthcare Operations per section 164.502(a)(1)(ii). This request is being made by the health plan and its Business Associate for determining eligibility and coverage under the plan, reviewing heath care services for medical necessity, coverage, justification of charges, and the like; and utilization review activities which are defined as Payment per section 164.501 of the Privacy Rule.