Care at Home Physician Communication Preference Form

Today's date: _____

PCP name: _____ Phone number: _____ Fax number: _____

Office address: _____ Suite: _____

City: _____ State: _____ Zip code: _____

Mailing address: _____ Suite: _____

City: _____ State: _____ Zip code: _____

To streamline our communications with you regarding your patients in our Care at Home program, please indicate how you would prefer us to reach you.

	Acute change in condition	Recommended changes in chronic treatment plan	Routine care plan updates
Telephone call	☐	☐	☐
Fax	☐	☐	☐
Mail	☐	☐	☐

Preferred phone number (if different than above): _____

Preferred secure fax number (if different than above): _____

Please fax this form to the Care at Home program at 1-844-574-2616 from your HIPAA-secure fax. The return of this document will serve as validation of your secure fax. Should you have any questions regarding this fax form and/or the Care at Home program, please contact us at 1-877-239-1491.

We look forward to assisting you and your team with your patients' care.

BlueShield
of Northeastern New York

9517_11_14