PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Missed Appointment Notification Form

Providers fax this form to Partnership's Member Services Department (707) 863-4415 attention: Enrollment Unit

Patient Name:	Date of Birth (MM/DD/YYYY):
Parent/Guardian Name (if applicable):	Phone Number:
Primary Diagnosis:	Partnership ID# (on the Partnership ID Card):
Dates of missed appointments within the last 3 months:	Dates of the last kept appointments:
If your request is from a specialist, has the PCP's office has been notified of missed appointments ☐ Yes ☐ No	
Was the patient notified or reminded of the appointment date(s) and time of the missed appointments listed above: ☐ Yes ☐ No When was the patient notified or reminded of the last scheduled appointment? _____ (date) How was the patient notified/reminded of the last scheduled appointment? ☐ at the physician's office ☐ over the phone ☐ by mail ☐ by email	
Were interventions attempted following the missed appointments above? ☐ Yes ☐ No If so, what were the interventions?	
What was the patient's response to your interventions?	
Name of Provider:	
<u>Person completing form</u> Name: Date form was completed:	Phone: Fax:

Partnership USE ONLY
Member was contacted by phone on (date):
Letter was sent to member on (date):
Reasons for missing appointments:
Comments:

Form #29

Care Coordination Referral: _____
CC: Provider Relations: _____