

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, PCP office has been notified of missed appointments <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the patient notified or reminded of appointment date and time: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> at the physician's office <input type="checkbox"/> over the phone <input type="checkbox"/> by mail <input type="checkbox"/> by email		
List interventions done when member missed appointments:		
What was the member'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: _____