Patient Foster Placement Information – for Cottonwood Pediatrics, 283-7100

Patient Name: _____ Patient Date of Birth: _____

Foster Parent(s) Name(s): _____

Foster Parent(s) Address: _____

Foster Parent(s) Phone Number(s): _____ Date of Placement: _____

Case Manager Name _____ Company/Office location _____

Office Phone Number:_____ Cell Phone _____ Fax _____

Case Number:_____ Today's Date: _____

Do providers have patient medical records? To provide appropriate medical care and meet KDHE requirements, providers must have the patient's past medical history, including but not limited to:

☐ **Current health or development concerns** ☐ **Current medications** ☐ **Any known drug allergies**	☐ **Immunizations** ☐ **Date of patient's last physical/Well Child Exam**

Do medical treatment facilities have the placement/guardianship papers for this patient on file? Facilities must have these records in the patient's chart to meet HIPAA regulations before seeing the patient.

Insurance coverage information: Is the patient covered under **more than one** insurance plan?
*(We need a copy of **each** insurance card)*
Patient Primary Insurance*: _____

Patient Primary Insurance ID#: _____ Group#: _____

Primary Insurance Policyholder Name: _____

Policyholder Date of Birth: _____ SSN:_____

Policyholder Address (Street, City, State and Zip): _____

Policyholder Phone Number: _____ Policyholder Employer: _____

→*For insurance purposes, may we contact the policyholder if we need additional information?* ☐ Yes ☐ No

Patient Secondary Insurance*: _____

Patient Secondary Insurance ID#: _____ Group#:_____

Secondary Insurance Policyholder Name: _____

Policyholder Date of Birth: _____ SSN: _____

Policyholder Address (Street, City, State and Zip): _____

Policyholder Phone Number: _____ Policyholder Employer: _____

→*For insurance purposes, may we contact the policyholder if we need additional information?* ☐ Yes ☐ No

****We do not accept KanCare Sunflower Health Insurance Plan**. See other side for further information.*

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If the patient does not have insurance coverage for the date services are provided:

Responsible party for payment of services:

Name _____

Address _____

Address _____

City, State, Zip _____

Phone Number _____

All services, with the exception of hospital services, must be paid OR an acceptable form of payment offered on the Date of Service.

Please note:

- **We do not accept KanCare Sunflower Health Insurance Plan**.
- We WILL accept KanCare Amerigroup, and KanCare United Healthcare Community Plan for a provider who has an open panel.
- One of our providers must be listed as the Primary Care Provider on the patient's insurance plan. *A PCP change form may need to be completed (Consider seeking care with PCP listed to maintain continuity of care.)*
- If the patient has commercial insurance coverage, w**e are UNABLE to see a patient who is locked in to another provider, especially under HMO plans.** *(If locked in, it may be advisable to seek care with PCP listed.)*