Health Information

ONE MEMBER PER FORM

Please take a few minutes to fill out this form. This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail. You may also fill this form out online at www.NebraskaTotalCare.com. If you have any questions, call Health Plan at 844-385-2192 (TDD/TTY:844-307-0342) or visit www.NebraskaTotalCare.com.

One Member per form

Member Last Name, First:

Date of Birth (MM/DD/YYYY):

*Medicaid ID:

Name of person answering questions:

Relationship to member:

☐ Parent ☐ Guardian ☐ Spouse ☐ Friend ☐ Lawyer ☐ Provider ☐ Other

If we would need to return a call to you, what is the best time to reach you?

☐ Morning ☐ Afternoon ☐ Evening

What is the best telephone number to reach you?

Member's Height: ☐☐ Feet ☐☐ Inches Member's Weight: ☐☐☐ Pounds

Do you know who your PCP (doctor) is? ☐ Yes ☐ No

Do you have an appointment scheduled with your PCP? ☐ Yes ☐ No

Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them? ☐ Yes ☐ No

Have you been admitted to a hospital in the last 12 months? ☐ Yes ☐ No

Have you been to the emergency room (ER) more than once in the last six months? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure ☐ N/A

Do you currently have any of the following conditions? (check all that apply)

☐ Alcohol or Substance Abuse ☐ Asthma ☐ Cancer ☐ COPD

☐ Depression ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ HIV/AIDS ☐ Kidney Disease ☐ Mental Health Condition

☐ Transplant (On waiting list or received transplant in the last 12 months) ☐ Tobacco use

Other medical condition(s)

Do you have any special needs (such as hearing, vision or mobility problems)? ☐ Yes ☐ No

If yes, please describe special needs

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Are you eligible to receive Indian Health Services? ☐ Yes ☐ No

Are you eligible for HCBS IDD Waiver services? ☐ Yes ☐ No