HealthPlan OF SAN MATEO

Provider Request for Member Reassignment

Provider's Information:

PCP/Provider Requesting: _____ Telephone #: _____

Member's Information:

Member Name: _____ Telephone #: _____

HPSM ID #: _____ DOB: _____

Reason for Request:

- ☐ abusive or disruptive
- ☐ inappropriate behavior
- ☐ failure to comply with medical advice
- ☐ missed appointments/no show
- ☐ late for appointments
- ☐ Other (describe) : _____

Were at least 3 warning letters (1 certified) sent to the member for the issue above? ☐ Yes ☐ No

Did you try to resolve the above issue with the member? ☐ Yes ☐ No

Have you completed HPSM's Complex Management form? ☐ Yes ☐ No

If yes, describe: _____

Please include a description of the issue and include documentation of all communication that you have had with the member that pertains to the reason for your request. Also, provide copies of letters sent to the member and medical records that encompasses documentation of the issue. Fax form to (650) 616-8046 or e-mail to: psinquiries@hpsm.org

The Provider Services Department will notify you with a decision within 14 business days.

For more information regarding Health Plan of San Mateo's Member Reassignment policy, please review the Provider Manual at www.hpsm.org/provider/resources/provider-manual

For HPSM Use Only:

Received by Provider Services: _____ Forwarded to Care Coordination: _____

G&A Report Requested: _____ G&A Report Sent to PS: _____

Letter Sent to HPSM Member: _____

☐ Approved ☐ Denied

Medical Director's Signature: _____ Date: _____