PINNACLE™ CLAIMS MANAGEMENT, INC.

PINNACLE HEALTH MANAGEMENT PROGRAM ENROLLMENT FORM

MEMBER INFORMATION

Name:

Phone:	Alternate Phone:	Best time to call: AM PM

Current address:

City:	State:	ZIP code:

Employer:	Health Plan ID (HPID)*:	Date of Birth: M F

*Your HPID number is located on your medical ID card

DOCTOR INFORMATION

Doctor's name and medical group:	Doctor's phone number:
Specialist:	Specialist phone number

HEALTH INFORMATION

Member Height	Member Weight:	Last blood sugar level:	Last blood pressure results:

HEALTH CONDITIONS THAT I NEED HELP WITH		HELP I CAN USE FOR MY CONDITION(S)	
Health Condition (Check all that apply)		**Assistance** (Check all that apply)	
	Diabetes		Learning about my risk for complications from my medical condition(s)
	Asthma		Education and information about my medical condition(s)
	High blood pressure		Help getting my lab tests done or obtaining prescriptions
	High cholesterol		Help getting needed medical screenings from my doctor
	Other medical concerns:		Help making doctor appointments
			Transportation issues
			Other

I understand that this authorization is voluntary and represents my personal intentions and that federal law allows Pinnacle Claims Management to release my personal health information (PHI) as part of the payment of claims or as part of its daily operations to the extent minimally necessary. I also understand that Pinnacle Claims Management may need to disclose my PHI to others outside of Pinnacle Claims Management for the purpose of providing services related to my specific plan. As a result, I authorize Pinnacle Claims Management to disclose my PHI as provided by law and in accordance with the standards established in the Health Insurance Portability Accountability Act (HIPAA).

Your health information and participation in the Pinnacle Health Management Program is strictly confidential. Your information is only shared with those designated health care professionals who are a part of your treatment plan.

Signature of member: _____ Date: _____