Provider Post Appointment Care Coordination Form

WelbeHealth PACE (Program of All-Inclusive Care for the Elderly) is responsible for developing and monitoring treatment plans for each participant in our program. The purpose of this form is to help your office easily communicate time-sensitive needs that are identified during/post-appointment to ensure care is appropriately coordinated by our interdisciplinary team.

Within 24 hours of appointment, fax this completed form to 855-712-7837

REMINDERS: Clinic documentation from visit must also be sent to WelbeHealth within 7 days of appointment to 855-712-7837
For scheduling, contact the Hub at (650) 336-0300.

THIS FORM IS NOT A REQUEST FOR AUTHORIZATION. Additional visits and/or services may require authorization. To determine if authorization is required, visit www.welbehealth.com/partners. All authorization requests must be submitted via the Provider Portal or fax a completed authorization form to (209) 729-5854.

Participant Information		
Participant Name:	**Date of Birth**:	**Participant ID Number**:
Provider Information		
Provider Name:	**Contact Name:**	**Phone**:
Clinic Address:		
Clinical Information		
Initial Date of Appointment: **Appointment Time**:	**Follow-Up appointment has been scheduled:** ☐ Yes ☐ **Yes - STAT** ☐ No **If yes:** **Date:** **Time:** **Address:**	
Medication Recommendations	**New**: **Stop**: **Change Dose** :	
Labs	**Ordered/Performed**: **Needed**:	
Imaging	**Ordered/Performed**: **Needed**:	
Additional Recommendations **(Ex. Procedures, Physical Therapy, Dietary, etc.)**		