AETNA BETTER HEALTH® OF NEW JERSEY
Transition of care form

Welcome to Aetna Better Health of New Jersey! It is important to us to be sure that your health care continues as you become a member of our plan.

Please fill out this form so that we can work with you to continue the care you have been getting and can help you get the medical care you need. Please return it in the envelope provided. If you have any questions, or would rather give these answers over the phone, call us toll-free at **1-855-232-3596, TTY 711,** 24 hours a day, 7 days a week.

Member name _____ Member ID #_____

Your name (if you are not the member) _____ Member date of birth _____

Relationship to the member_____ Phone number (____)_____

Member address_____ _____

Health care now

1. Do you have a doctor that you are seeing now? ☐ Yes ☐ No

If yes, please list your doctor's name _____ Phone number (____)_____

2. Do you need a new doctor? ☐ Yes ☐ No

3. Have you chosen a new doctor? ☐ Yes ☐ No ☐ Not Applicable

If yes, please list your doctor's name_____ Phone number (___)_____

4. Have you scheduled an appointment with your new doctor? ☐ Yes ☐ No

5. What doctors do you see now?

Doctor's name_____ Phone number (___)_____

See this doctor for_____

Doctor's name_____ Phone number (___)_____

See this doctor for_____

6. Are you pregnant or have you had a baby in the last 30 days? ☐ Yes ☐ No

If yes, when are you due? When did you deliver? Date _____

Do/did you have a doctor for this pregnancy? ☐ Yes ☐ No

Doctor's name_____ Phone number (___)_____

7. Are you currently getting home health services? ☐ Yes ☐ No

8. Are you currently using medical equipment (like a wheelchair, oxygen or breathing machine)? ☐ Yes ☐ No

9. Are you scheduled for or are you receiving any of the following?

☐ Elective surgery ☐ Physical, speech or occupational therapy (underline which ones)

☐ Rehabilitation therapy ☐ Cancer treatment

☐ Substance abuse treatment ☐ Mental health treatment

☐ Kidney dialysis ☐ Other_____

Medicines

1. Are you currently taking prescription medicines? ☐ Yes ☐ No

2. Do you think you may have a problem getting any prescriptions filled over the next 90 days? ☐ Yes ☐ No

3. What is your preferred pharmacy and location?

_____

Health history

1. Have you been told you have any of the following? Please check all that apply.

☐ Asthma ☐ Diabetes (sugar)

☐ Chronic obstructive pulmonary disease (COPD) ☐ Congestive heart failure (CHF)

☐ Coronary artery disease (CAD or heart disease) ☐ Substance abuse problems

☐ HIV / AIDS ☐ Behavioral or mental health disorder

☐ Cancer Type_____ Date _____

☐ Organ transplant Type_____ Date _____

☐ Other _____

2. Are you having problems getting any health services? ☐ Yes ☐ No

3. Do you want us to call you about any of your concerns? ☐ Yes ☐ No

If yes, what is the best way to reach you? _____

If yes, what is the best day and time to reach you? _____

4. What language is best for you? ☐ English ☐ Spanish ☐ Other Language _____

☐ Do you have other communication needs? (like-TTY/TDD) _____

Please complete and return in the pre-addressed envelope provided or mail to:
Aetna Better Health of New Jersey
3 Independence Way
Princeton, NJ 08540

Questions?
Call toll-free **1-855-232-3596, TTY 711, 2**4 hours a day, 7 days a week or visit
www.aetnabetterhealth.com/newjersey