

Care Coordination Form

Cox HealthPlans would like to assess and help coordinate your care as you transition onto our plan. Please fill out this form and include any course of treatment you are currently undergoing and the providers you are seeing. Examples of “course of treatment” may include but are not limited to complex wound care, chemotherapy, or radiation therapy. **Case Management services are provided at no cost!**

Please send this form to us via fax (417) 269-2919. We look forward to helping you!

Your First/Last Name: _____ Date of Birth ____/____/____

Most convenient way to reach you by phone between 8:00AM – 5:00PM:

Home: _____ Cell: _____ Work: _____

E-Mail: _____

Do you have a Primary Care Provider? If so, please provide their information.

Your Primary Care Provider (First, Middle, Last Name): _____

Location: _____ Phone: _____

Pharmacy: _____ Location: _____

Do you see a Specialist? If so, please provide their information.

Your Specialist (First, Middle, Last Name): _____

Location: _____ Phone: _____

Pharmacy: _____ Location: _____

Please list any conditions you are currently in active treatment for:
