Medical Helpline

Continuity of Care Request Form

EMPLOYEE INFORMATION	
Employee:	SSN or ID#:
Address:	City:
State:	Zip Code:

PATIENT INFORMATION	
Patient Name:	
Address:	
Home Phone:	
Cell Phone:	
May Medical Helpline Representatives leave a voice-mail message? ○ Yes or ○ No	
If Yes, which number do you prefer?	Phone Number:
May we send you a text? ○ Yes or ○ No	
May we contact you by email? ○ Yes or ○ No	
Email Address:	

PHYSICIAN & TREATMENT	
Treating Physician's Name:	Phone Number:
Treating Physician's Address:	Treating Physician's Specialty:
How long has Physician been treating Patient?	
Is there an anticipated end for the current treatment?	
Hospital/Facility if applicable:	
PCP Name:	Phone Number:

Briefly describe the condition, treatment, duration of treatment and any planned procedures.
(Please use a separate sheet for additional comment.)

9/18/18

Fax completed form to | **1.281.886.0973**
90DegreeBenefitsTX.com

The Right Turn For Your Benefits

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