Health-Related Services:
Flex Form

CareOregon

Please see the health-related service instructions page on how to fill out this form.

Please mark the type of insurance you have:

◯ health share Health Share of Oregon ◯ Columbia Pacific CCO™ ◯ Jackson Care Connect™

Date (mm/dd/yyyy): _____

Member legal name: _____

Other name(s) used: _____

Medicaid ID#: _____

Date of birth (mm/dd/yyyy): _____

If different then the member, person submitting the form, relation, and contact information:

_____

Who needs to be contacted about the request? Check all that apply:
Member ◯ Submitter ◯ Both ◯

How would you like to be contacted about this request?

A: ◯ Phone _____

B: ◯ Email _____

C: ◯ Other _____

1. When do you need this item delivered or paid for by? (mm/dd/yyyy): _____
2. What medical symptoms or medical diagnoses would this item help you with, and why?

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3. What other resources have you tried to access in order to pay for this service or purchase this item?

4. Please describe the item or service you need. If your request is for an item, add any details of the brand, type, size, color, and any other important details. If the request is for rent or utilities, please include the months needed for payment and/or any late fees, or utilities included in rental agreement:

5. What is the total cost of the item or service, including any additional fees such as shipping?

6. What is the delivery address that the item or payment needs to be sent to? Please note items larger than an envelope will need to be sent to a safe physical address, not a PO box.

7. Who are we making payment to? Or where are we purchasing the item? Please include links if appropriate and possible

8. HRSF is for temporary funding support; what steps are you taking to be able to pay for this item or service in the future?

9. Have you received this item or service from CareOregon before? ◯Yes ◯No

10. Have you received this item from CareOregon in the last 6 months? ◯Yes ◯No

    10a. If both are yes, why are you asking for this item or service again?

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11. I confirm that this form was filled out and sent in with my knowledge and permission and I am interested in someone making contact with me or my personal representative.

    Member Initials: _____

Member attestation and authorization

By signing this form , I understand and agree to the following:

- ◯ If approved, I agree to receive the services requested above.
- ◯ My health plan can contact me to get more information about this request.
- ◯ I sign under penalty of perjury. That means, to the best of my knowledge, all the information I gave in this request is true, correct and complete.
- ◯ If I provide false or untrue information, I may be subject to penalties under state or federal law. This may include having to pay back money spent on any services I receive because of this request.

Signature of person submitting form: _____

Date (mm/dd/yyyy): _____

Fax completed forms to: 503-416-4728

Email completed forms to: ***Requests.Social.determinants@careoregon.org***

If you have questions about HRSF, need help filling out the form, or wish to file a grievance, please call CareOregon Customer Service at 503-416-4100 or 800-224-4840 TTY 711

You can get this in other languages, large print, braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 866-952-0083 or TTY 711. We accept relay calls.

OHP-XXX-XX-XXXX