Case Management Consent Form

Patient Name: _____	Patient DOB: _____	Patient ID#: _____

I, _____, as a member, spouse, or legal guardian of the above member
PRINT NAME
agree to participate in the Case Management Program administered by Resurrection Physicians Provider Group for Blue Cross Blue Shield of Illinois HMO Illinois /BlueAdvantage HMO plan.

I understand that this agreement to participate means:

- I consent to the patient and/or family being contacted by the Case Manager assigned by Resurrection Physicians Provider Group.
- I consent to providers of health care services (hospital staff, physicians, therapist, etc.) being contacted for information about the patient related to the development, implementation and evaluation of a Case Management Program care plan and for the processing of claims for the services provided under the Program.
- I authorize the release of medical information for the purpose stated above.
- I understand that the Case Management Program is voluntary and I may withdraw from the program at any time upon notification to Resurrection Physicians Provider Group's Case Manager or my Primary Care Physician. If I withdraw, my contract benefits, as described in the Benefit Booklet will continue.
- I understand that I should retain a copy of this document for my records and that a photocopy of this form is as valid as the original.
- I have read the above (or the above has been explained to me) and I hereby agree to participate in the Case Management Program and am bound by the contractual provisions of my health insurance contract.
- I understand the information provided or explained to me regarding the Program.
- I understand that if I am dissatisfied with the care or services, for any reason, I can call the Resurrection Physicians Provider Group's Case Manager at 773.695.4800 Monday through Friday, between the hours of 8:00 am and 4:30 pm.

☐ I choose **NOT** to accept Case Management services.

_____	_____	_____
Signature	Relationship to Patient	Date

If someone else is signing this authorization form on behalf of the member, please provide the following:

*Legal Representative's name: _____

Relationship to the member: _____

*Note: *Provide written documentation to support your status as a guardian or other legal representative.*

Please complete and return this form within (30) calendar days of receipt.