Health Information Form

Questions?

📞 call 1-866-912-6285, Relay 711
orWhere visit
✉ MagnoliaHealthPlan.com

Please take a few minutes to fill out the form on the other side, or fill it out online – MagnoliaHealthPlan.com
This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail.
One Member per Form

Member First Name: __________________________ Last Name: __________________________
Medicaid ID*: __________________________ Member Date of Birth (mmddyyyy): __________________________
Race/Ethnicity (fill in all that apply): Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐
American Indian/Native American ☐ Asian ☐ Hawaiian/Pacific Islander ☐
Name of Person Answering Questions: __________________________
Relation to Member: Parent ☐ Guardian ☐ Spouse ☐ Friend ☐ Lawyer ☐ Provider ☐ Other ☐
If we would need to return a call to you, what is the best time and telephone number to reach you?

Morning ☐ Afternoon ☐ Evening ☐ Telephone number: _______ - _______ - _______
Member Height: _______ feet _______ inches Member Weight: _______ pounds

1. Do you know who your PCP (doctor) is? Yes ☐ No ☐
   PCP’s Name: __________________________
   PCP’s Phone Number: _______ - _______ - _______
   When did you last see your PCP? Less than 3 months ago ☐ More than 3 months ago ☐ Never ☐
   Do you have an appointment scheduled with your PCP? Yes ☐ No ☐ If Yes, when? __________________________

2. Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them?
   Yes ☐ No ☐

3. Have you been to the Emergency Room (ER) more than once in the last six months? Yes ☐ No ☐
   Have you been admitted to a hospital in the last 12 months? Yes ☐ No ☐
   If yes, what was the reason for admission? __________________________

4. Are you currently pregnant? Yes ☐ No ☐
   If yes, please answer the following and complete a pregnancy form.
   The form is on our website and included in your member welcome packet.
   Name of the doctor caring for you during this pregnancy: __________________________
   Your Baby’s Due Date (mmddyyyy): __________________________

5. Do you currently have any of the following conditions? (check all that apply)
   ☐ Alcohol or Substance Abuse ☐ High Blood Pressure ☐ Other Medical
   ☐ Asthma ☐ HIV/AIDS ☐ Condition(s) Please List.
   ☐ Cancer ☐ Kidney Disease ☐
   ☐ COPD ☐ Mental Health Condition ☐
   ☐ Depression ☐ Transplant (on waiting list or received transplant in the past 12 months)
   ☐ Diabetes ☐ Tobacco Use
   ☐ Heart Disease ☐
   ☐ Do you have any special needs (such as hearing, vision or mobility problems)? Yes ☐ No ☐
   Please List: __________________________

If you are currently having any problems (physical, social, behavioral) that you would like to talk to a Magnolia Health staff person about, please call us at 866–912–6285 (toll free #). Magnolia Health will use the information on this form to help you get healthcare services. Your information will be kept private and confidential, as required by State and Federal law. For more information, please see the Notice of Privacy Practice section of your member handbook or call us at 866–912–6285, Relay 711.