«plan name»
«address1» «address2»
«city», «state» «zip»

«firstname» «lastname»
«address1» «address2»
«city», «state» «zip»

Member Name: {_____}
Date of Birth: {_____}
Identification Number: {_____}

Dear «firstname» «lastname»:

Welcome to Case Management!

This letter serves as an introduction of case management services that have been identified on your behalf by <Insert Plan Name>. It also confirms your agreement to participate in our Case Management Program. Case management is a voluntary program designed to help you coordinate health care benefits for your medical conditions or chronic care needs with a goal to help improve your health. Case management services are provided at no additional cost to you.

Licensed health care professionals trained in case management and familiar with your benefit plan provide these services. I have been assigned as your Case Manager. My role is to help you and your health care providers optimize your health care benefits. I will work with you and your physician as needed to develop a case management plan that is designed to help meet your needs by using available benefits and resources.

I will stay in contact with you by telephone on a periodic basis. If you have any questions or needs regarding your case management plan, please call me at the number below. You may receive written notifications of case management actions and recommendations, such as when a significant change occurs in your care management plan. To assist you with the coordination of health care services, there may be times when certain information needs to be shared with your treating physician or other health care provider.

Please take a moment to read over the attached Member Bill of Rights. **Please sign and return the last page of this letter to the address noted on the form within 7 calendar days.**

If you would like to give us permission to speak to your family or friends about your case management plan, please ask us for a HIPAA Authorization form.

If you have any questions about the Case Management Program, how you were selected for case management services, or reasons for ending case management services, please contact me at the number or address listed below. If you have complaints or concerns regarding services provided under the Case Management Program, call the Customer Service number on the back of your health insurance ID card from <hours of operation>.

Sincerely,

Case Manager

Title
Plan
Address
Phone #

Enclosure

<Insert Plan Name> Case Management Program

Member Bill of Rights

As a member of <Insert Plan Name>, you have the right to:

- Confidentiality and privacy of health information in accordance with state and federal law.
- Be understood and treated well, even if you have limited English skills, a different cultural background, or a disability.
- Receive information in a language or method you can understand.
- Take part in decisions about your health care treatment with your doctor.
- Designate or authorize another party to act on your behalf.
- Have your advance medical directives (living will and/or medical power of attorney) respected and honored by your health care provider(s).
- Express concerns and complaints about care and services you receive.
- File a complaint without fear of reprisal.

As a participant in <Insert Plan Name> Case Management Program, you have the right to:

- Have case management services provided with respect and dignity, and without discrimination.
- Provide input to the Case Management Plan developed by the Case Manager to address your identified health care needs.
- Receive a copy of your Case Management Plan upon request.
- Know and understand the reasoning for selecting cases for case management and for ending or closing case management services.
- Question how decisions are made regarding your eligibility for case management services.
- Receive notification when case management services are changed or terminated and the reason(s) why.
- Be informed of choices regarding case management services.
- To have others involved in your care to participate in the case management assessment.
- Refuse or disenroll from case management services, with an explanation provided to you on the implications of refusal in relation to your benefits and health conditions.

Agreement to Participate in the Case Management Program

Please sign and return this page to:

<Insert Plan Name>
Address Line 1
Address Line 2
City, State, Zip
or
Fax this page to (000) 000-0000

- I agree to participate in the Case Management Program offered by <Insert Plan Name>.
- I understand that it is a voluntary program provided at no additional cost to me.
- I have read this letter and understand the information in it.
- I have also read and understand the information listed in the "Member Bill of Rights" section of this letter.

Member's Name: *(prints from system)*

Member's ID Number: *(prints from system)* **Date of Birth:** *(prints from system)*

Phone Number: _____ **Best Date/Time to Call:** _____

Member's Signature:

_____ **Date:** _____

Authorized Representative (Complete Only If Applicable)

Name of Authorized Representative (Please Print): _____

Relationship to Member: _____

Signature of Authorized Representative:

_____**Date:** _____