

Disease Management Consent Form

I, "[Click here and type NAME, Date of Birth, PID]" agree to participate in the Disease Management Program administered by INETICARE for "[Click here and type name of the insurer and group #"]

CHECK ONE OF THE TWO OPTIONS BELOW

I understand that this agreement to participate means:

- I consent to the patient and/or family being contacted by the Care Manager assigned by **INETICARE**.
- I consent to providers of health care services (hospital staff, physicians, therapist, etc.) being contacted for information about the patient for the development, implementation and evaluation of a Disease Management Program Care Plan and for the processing of claims for the services provided under the Program.
- I understand that INETICARE will release only information necessary for appropriate benefit management and/or to arrange medical and/or social services.
- I authorize the release of medical information from all my health care providers (hospital staff, physicians, therapist, etc.) for the purpose stated above to INETICARE and its representatives according to HIPAA regulations. This information may be released by my attending physician or other medical professionals who have treated me. This information specifically may include details relating to alcohol or drug treatment, mental health treatment, communicable-diseases such as hepatitis or HIV, or any other medical condition or treatment. I fully understand that the intent of this authorization to secure information is solely for the purpose of Disease Management and/or rehabilitation plan development on behalf of [Click here and type Client/Designee].
- I understand that the Disease Management Program is voluntary and I may withdraw from the program at any time upon notification to **INETICARE's** Care Manager. If I withdraw, my contract benefits, as described in the Benefit Booklet, will continue.
- I understand that the information that is disclosed in accordance with this authorization may be disclosed by the recipient to the payer and that the information may no longer be protected by Federal privacy rules regarding protected health information.
- 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 Disease 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 involvement in the Disease Management Program provides the program with the ability to communicate with treating providers for urgent or non-urgent circumstances or to discuss variances in the treatment plan.
- I understand that if I am dissatisfied with the care or services, for any reason, I can call the **INETICARE** Care Manager or Quality Assurance Department at **877-608-2200**(toll free), Monday through Friday, between the hours of 9:00 am and 5:00 pm ET.

I choose **NOT** to accept Disease Management services.

Signature

Relationship to Patient

Date

If signing for a minor child, please state your relationship (e.g. Mother, Father, guardian, etc.) If signing on behalf of someone else, such as a spouse, please state your relationship and the reason the person/insured is unable to sign for him/her.

This document is valid for one year post-signature.

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:

*Please provide written documentation to support your status as a guardian or other legal representative.

Please complete and return in the enclosed stamped self-addressed envelope upon receipt or within fifteen (15) calendar days of receipt of letter. This consent is valid for one year post signature.