Transition of care request

To be completed by current attending provider

eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Member name	Date of birth (mm/dd/yyyy)	Subscriber ID	Patient phone
Provider/physician		Contact name	Provider/physician phone
Facility (if applicable)		Admit date	Facility phone
Diagnosis			
Service/Procedure(s)			If pregnant, due date
Requested Date Span			

Please include a brief clinical summary of patient's condition and treatment plan below:

Provider signature

Date

Ready to submit?

Email or fax this form to EOCCO supporting clinical documentation

Email: transitionofcare@modahealth.com | **Fax:** 503-243-5105

Questions? Contact EOCCO at 888-393-2940. (TTY users, please dial 711.)

eocco.com

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