**Medical Respite Facility Form**

Anthem Blue Cross offers medical respite beds for members who are homeless in L.A. County through National Health Foundation. By completing this form, I ask the member named below be referred for services.

**Member information**

Name (first, last):  Female  Male

Medi-Cal ID number: Date of birth:\_\_\_/ \_\_\_/

Street address:

City: State: ZIP code:

Phone/cell number:

**Hospital/skilled nursing facility information**

Discharge planner’s name:

Facility name:

Address:

City: State: ZIP code:

Phone/cell number:

Email:

**Medical respite facility information**

Receiving facility staff name:

Facility name:

Address:

City: State: ZIP code:

Phone/cell number:

Email:

I have read the contents of this form. I understand, agree and allow Anthem to use and release information from this form or that Anthem has about the member to third parties, including member’s health care providers and the National Health Foundation to arrange the service requested. I understand that signing this form is of my own free will. I understand Anthem does not require I sign this form in order for me to receive treatment or payment or for enrollment or being eligible for benefits under my health plan. However, I understand Anthem may not be able to refer me to the National Health Foundation unless I authorize them to do so.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem. This approval will be effective until it is withdrawn. I understand my withdrawing this approval will not affect any action taken before I do so. I also understand information that’s released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Date:

Signature (parent or guardian if member is a minor)

Call for questions or comments: 1-800-407-4627 (TTY 1-888-757-6034)

**www.anthem.com/ca/medi-cal**

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