



**Please take a few minutes to fill out the form on the other side.
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.

If you have any questions, please call
CeltiCare Health Plan of Massachusetts at 1-866-895-1786.

You will automatically get \$50 on a personalized prepaid CeltiCare CentAccount® card just for sending this form back!

For information on more ways to earn money on your CeltiCare CentAccount® card, call CeltiCare at **866-895-1786** (TDD/TTY: 866-614-1949) or visit **www.celticarehealthplan.com**.

Member Name: Member ID Number:

1. What conditions have you been treated for or are currently being treated for? (check all that apply)

Condition	Medications Used for Condition (if applicable)
<input type="radio"/> Alcohol/Substance Abuse
<input type="radio"/> Asthma
<input type="radio"/> Blood Clots (current or prior)
<input type="radio"/> Cancer
<input type="radio"/> Cholesterol
<input type="radio"/> COPD
<input type="radio"/> Diabetes
<input type="radio"/> Heart Disease
<input type="radio"/> HIV/AIDS
<input type="radio"/> Hepatitis
<input type="radio"/> Hypertension
<input type="radio"/> Kidney Disease
<input type="radio"/> Mental Health Condition
<input type="radio"/> Migrane
<input type="radio"/> Osteoporosis
<input type="radio"/> Transplant
<input type="radio"/> Other Medical Condition(s)
<input type="radio"/> Other Medications: including over the counter vitamins, calcium, iron, aspirin, acetaminophen, etc.
<input type="radio"/> N/A

2. Are you having a problem with any of your medications that prevent you from using them according to how your doctor ordered them? Yes No

3. Have you been admitted to a hospital in the last 12 months? Yes No
If yes, what was the reason for admission?

4. Have you been to the emergency room (ER) more than once in the last six months? Yes No

5. Are you experiencing any of the following symptoms? (check all that apply)
 Shortness of breath Chronic cough Dizziness or light-headedness that reoccurs N/A

6. Do you receive any of the following services? If so, please explain. (check all that apply)
 Equipment to help you walk Home medical equipment N/A
 Home healthcare Home oxygen therapy

7. Are you currently pregnant? Yes No (If yes, please answer the following and complete and return the enclosed pregnancy form.)
Doctor Name (OB): Baby Due Date:

8. If we have a question, what is the best time and telephone number to reach you?

9. CeltiCare has my permission to use my health information to carry out treatment, payment, health care operations or other uses and disclosures required by law. CeltiCare has my approval to report my health information to the state agency (Connector Authority) to assist in gaining health care services, coverage and benefits that my condition may qualify me (or my child) for enrollment in. Yes No