CHAMPION HEALTH PLAN

Bridge Case Management Form

New enrollee's name	
Does enrollee receive hemodialysis?	☐ Yes ☐ No
Does enrollee receive peritoneal dialysis?	☐ Yes ☐ No
Dialysis center name	
Dialysis center address	
	City | Zip
Dialysis center phone number	
Does the enrollee need assistance with transportation?	☐ Yes ☐ No
If yes, does enrollee have any special requirements such as wheelchair, gurney, door to door, or curb to curb?	☐ Yes ☐ No Please list:

In addition to your Nephrologist, what other routine care/providers you see?
List all that apply: specialists, home health, medical equipment/supplies, etc.
We will contact them to request that they continue providing care for you.

Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	☐ Yes ☐ No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	☐ Yes ☐ No
Name of Provider	
Phone number or address	
Date of next appointment	
Transportation assistance required?	☐ Yes ☐ No

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