INTERNAL USE ONLY:
Providers Verified__________
Checked for CM/HCC________
Checked for GA __________
HNA Entered ____________

Please complete and return this form directly to Quantum Health using the enclosed "Coordinated Health/Care" self-addressed stamped envelope

CONFIDENTIAL

Health Needs Assessment

Employee First Name

Employee Last Name

This Health Needs Assessment helps the Care Coordinators identify your covered family member's healthcare needs. On this side, please list:

1. **All specialty physicians that your insured family members are under care with (do not list your Primary Care Physician/Family Doctor).**
2. **All clinics, centers, and hospitals where you have procedures such as surgery, MRI, CAT scan, etc. already scheduled.**

1

Provider's Last Name or Facility Name | Provider's First Name | Family Member Being Treated

Provider Address | Telephone (with area code)

City | State | Zip | Type of Specialist

Describe procedure/surgery and date scheduled ---> MM/DD /YYYY / /

2

Provider's Last Name or Facility Name | Provider's First Name | Family Member Being Treated

Provider Address | Telephone (with area code)

City | State | Zip | Type of Specialist

Describe procedure/surgery and date scheduled ---> MM/DD /YYYY / /

3

Provider's Last Name or Facility Name | Provider's First Name | Family Member Being Treated

Provider Address | Telephone (with area code)

City | State | Zip | Type of Specialist

Describe procedure/surgery and date scheduled ---> MM/DD /YYYY / /

4

Provider's Last Name or Facility Name | Provider's First Name | Family Member Being Treated

Provider Address | Telephone (with area code)

City | State | Zip | Type of Specialist

Describe procedure/surgery and date scheduled ---> MM/DD /YYYY / /

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Please Complete Other Side---->