NOTES ABOUT MY SELECTHEALTH MEDICAID PLAN

Year: ____________________________

My Insurance Company: SelectHealth

> Website: selecthealth.org/plans/medicaid

> Phone Number: 855-442-3234

My plan is called Community Care

My Medicaid ID number ____________________________

My Primary Care Doctor ____________________________

Phone Number ____________________________

My next appointment is ____________________________

Other Providers/Doctors ____________________________

Phone Number ____________________________

My next appointment is ____________________________

To maintain Medicaid eligibility, I need to re-apply by ____________________________ (date)

Do you have questions about your Medicaid eligibility and/or application form?

Contact your Coverage to Care Specialist, ____________________________ at ____________________________ to answer questions and help walk you through all your options for maintaining health insurance.

Clinic Hours ____________________________ Weekdays ____________________________ Weekends

After-hours phone number ____________________________

Health Program Representatives (HPRs) will help you understand your Medicaid benefits and provider options. To contact an HPR, please call 866-608-9422.

If you have questions about your eligibility, please contact Department of Workforce Services (DWS-Medicaid/Chip) at 801-526-0950 or visit jobs.utah.gov/mycase.
Non-Emergency Medical Transportation

**NON-EMERGENCY MEDICAL TRANSPORTATION**

Medicaid may provide non-emergency transportation in an effort to help you get medical care if you are currently eligible for traditional Medicaid services and do not have transportation to receive medical treatment.

Non-Traditional, PCN, CHIP, UPP, QMB, SLMB, QI and Emergency Medicaid recipients are NOT eligible for non-emergency medical transportation or reimbursements. Transportation is not available for services from non-Medicaid providers or for non-Medicaid covered services. Transportation is not available to pick up prescriptions unless you are on the way to or from a medical appointment with a qualifying Medicaid provider. For information on exceptions, contact your Medicaid eligibility worker. Your eligibility worker may ask you to verify medical appointments. Medicaid may not reimburse you for all services.

**NURSING HOME RESIDENT TRANSPORTATION**

Nursing homes are required to provide transportation to medical appointments for their residents. Residents cannot receive bus passes. Any other non-emergency transportation needed that the nursing home does not provide requires prior authorization.

**UTA BUS PASSES**

You may receive a bus pass if you have Traditional Medicaid and live in an area served by UTA or Cedar Area Transportation Services (CATS). A bus pass has 12 one-way trips and also works on light-rail. More trips may be approved when the household has two or more recipients or when someone needs a companion. Only Medicaid recipients may use the bus pass and it may not be used for travel for work, school, shopping, etc.

**PARA-TRANSIT BUS SERVICES**

Para-Transit Bus Services are available in some areas. If you live in an area served by FlexTrans, contact Medicaid to find out if you qualify to receive FlexTrans vouchers.

**FLEXTRANS**

Salt Lake and Davis Counties: 801-287-7433

Davis, Weber and Box Elder Counties: 877-882-7272

Dial-A-Ride

CATS: 435-865-4510

**LOGISTICARE**

If you do not live in an area served by bus, para-transit services, or you need door-to-door service, you may be eligible for LogistiCare services. To find out if you are eligible, contact LogistiCare at 855-563-4403 and provide the doctor’s name and fax number who will be completing the required mobility evaluation form for you. Verify that the doctor is willing to complete the form before contacting LogistiCare. You may be transported by LogistiCare for up to four weeks while your eligibility is being determined.

You must schedule LogistiCare appointments three business days in advance by calling 855-563-4403.

They may provide some urgent care services for recipients that need to be seen within 24 hours. You must specify that the appointment is for urgent care. Verification may be required.

**PERSONAL MILEAGE REIMBURSEMENT**

**Local Travel**—When public transportation is not available or does not meet your needs, you may be reimbursed for personal mileage at 18 cents per mile, up to $300 a month. You must keep a mileage log showing the dates and miles traveled.

**Outside Your Local Area**—When treatment is not available in your local area, you must receive treatment from the nearest Medicaid provider who is able to provide the service or you cannot be reimbursed for mileage. Verification may be required.
Getting the Most out of Your Visit

Your name __________________________ Doctor’s name __________________________ Date ______

TELL US WHY YOU’RE HERE
This will help your doctor(s) give you the best care.

What type of care are you here for today?
Check one:
☐ I’m here about a recent illness or injury.
☐ I’m here about an ongoing problem such as diabetes, heart disease, kidney disease, or depression.
☐ I’m here for a routine check, screening, vaccination, or advice to help me stay healthy.

If you need help with more than one type of visit, you may need to make a separate appointment.

What do you want to get out of this visit?
Write what you most want to talk about or do today.

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

4. __________________________________________________________

During your visit, ask questions. If your doctor doesn’t explain things in a way you understand, keep asking. It’s their job to make sure you know what to do.

TAKE NOTES DURING YOUR VISIT
Fill this out in your own words. Before you leave, be sure you and your doctor agree on what to do next.

What’s my main problem? __________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
What do I need to do about it?
If there’s anything you feel you cannot do, let us know. There may be something else you can do instead.

I need to: ____________________________________________

__________________________________________________________

__________________________________________________________

It’s important for me to do this because: _______________________

__________________________________________________________

__________________________________________________________

I need to: ____________________________________________

__________________________________________________________

__________________________________________________________

It’s important for me to do this because: _______________________

__________________________________________________________

__________________________________________________________

When do I make another appointment? ________________________

__________________________________________________________

__________________________________________________________

What should I watch out for? ________________________________

__________________________________________________________

__________________________________________________________

Who do I call if I have questions?
Name and phone: ___________________________________________

__________________________________________________________

__________________________________________________________