Healthcare Contacts

Healthcare Navigation Library

Knowledge is your best benefit.

Healthcare Navigation Library

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Primary Care Provider	
Name:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____

Specialist #1	
Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	

Specialist #2	
Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	

Specialist #3	
Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	

Specialist #4	
Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	

Specialist #5

Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	

Pharmacy

Name:	_____
Phone:	_____
Address:	_____

Insurance Company	
Company:	_____
Member ID:	_____
Customer Service:	_____
Nurse Advice Line:	_____
Case Manager:	_____
Prior Authorization:	_____

Hospital	
Name:	_____
Phone:	_____
Address:	_____

Emergency Contacts	
1.	_____
Relationship:	_____
Phone:	_____
2.	_____
Relationship:	_____
Phone:	_____

Other Important Contacts	
Home Health:	_____
Hospice:	_____
Medical Equipment Supplier:	_____
Social Worker:	_____
Transportation:	_____
Caregiver Coordinator:	_____
Other:	_____

Important Notes
_____
_____
_____
_____
Bring this form with you to appointments and keep it in your Healthcare Navigation Binder.
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FL-004 — Healthcare Contacts

Extension Page

Need more room?

Print this page as many times as needed and keep it in your Healthcare Navigation Binder.

Specialist

Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	
_____	

Specialist

Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____

Notes

_____

_____

_____

Specialist	
Specialty:	_____
Provider:	_____
Clinic:	_____
Phone:	_____
Fax:	_____
Address:	_____
Patient Portal:	_____
Notes	
_____	
_____	
_____	

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