UR Medicine Geriatrics Group

Thank you for choosing to become part of UR Medicine Geriatrics Group. We look forward to bringing you something that's very hard to find these days: high-quality medical care delivered where you live, letting you avoid the inconvenience of traveling out.

Our medical practice specializes in caring for the elderly and comprises physicians, nurse practitioners, and physician assistants and is affiliated with UR Medicine and Highland Hospital.

We have partnered with senior living communities throughout the Rochester area to provide residents with personalized medical care in the privacy and comfort of their own living area. Our providers are available for you 24 hours a day, 365 days a year.

When you need us, we'll be there.
We're just a phone call away.
(585) 276-0830.

UR MEDICINE
Geriatrics Group
Part of Highland Hospital

Welcome to UR Medicine Geriatrics Group

Our caregivers will visit for both routine scheduled visits and any unexpected needs or problems that may arise. Having your health care practitioner see you in your home environment is convenient and ensures that you and your family members have enough time to discuss your care with your doctor in a relaxed environment. We also have on-call providers available to you to address any concern, at any time of the day or night.

In the event you or your loved one chooses to transfer from our services, you must arrange for a primary care provider within the community to care for you. In the interim, we will cover your care for 30 days after transferring of services.

Ensuring a Smooth Transition to URMGG

Together we can make your transition to being our patient as smooth as possible. Please complete the forms on the next several pages to the best of your knowledge. These forms comprise our New Patient Packet and provide us with a brief summary of your previous medical, social, and family history. Please remember:

- It is very important that all documents are signed by the patient or Power of Attorney/ Health Care Proxy where indicated.
- It is also crucial to include a copy of your insurance information and POA/HCP form.

New patient appointments are scheduled within a 2-3 week time frame after receiving the proper completion of the registration documents, processing the paperwork, and receiving your prior medical records. Our caregivers prefer to review your prior health history to become familiar with your background before meeting.

Your current primary physician should continue to cover your medical needs until our staff has made your initial

appointment, at which time we would then assume medical care on the appointment date we have scheduled.

Please note, your current primary care office has been notified of the date of your new patient visit with UR Medicine Geriatrics Group. For clinical questions or prescription refills prior to your new patient visit, your current physician will be responsible to address your concerns.

Please Do Not Hesitate to Contact Us With Any Questions

UR Medicine Geriatrics Group
Division of Geriatrics & Aging

Phone: (585) 276-0830

Fax: (585) 424-4184

1870 S. Winton Road, Suite 100
Rochester, NY 14618

UR MEDICINE
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Facilities

UR Medicine Geriatrics Group brings integrated care programs to patients at partner assisted living facilities and nursing homes throughout the area. Below is a complete list of all the facilities where our geriatricians provide primary geriatric care.

Assisted Living and Independent Facilities

• Baywinde	Kidd Castle Way, Webster
• Brookdale Pittsford	Sully's Trail, Pittsford
• Clark Meadows	Clark Meadows, Canandaigua
• Cloverwood	Sinclair Dr., Pittsford
• Cobbs Hill Manor	Monroe Ave., Rochester
• Creekstone	Ranney Dr., Fairport
• Elderwood at Fairport	Chardonnay Dr., Fairport
• Ferris Hills	Ferris Hills, Canandaigua
• Glenmere	Sinclair Dr., Pittsford
• GrandeVie	Five Mile Line Rd., Penfield
• GrandeVie- Villagewood & Caring House	Five Mile Line Rd., Penfield
• Heather Heights	West Jefferson Rd., Pittsford
• Heathwood	Elderwood Court, Penfield
• Highlands at Pittsford	Hahnemann Trail, Pittsford
• Horizons - DePaul	NY Route 21, Canandaigua
• Legacy at the Fairways	High Street, Victor
• Linden Knoll	Linden Ave., Rochester
• Maiden Park	749 Maiden Lane, Rochester
• Morgan Estates	Morgan View Rd., Geneseo
• Parkside	Main St., East Rochester
• Quail Summit	Parrish Street, Canandaigua
• Rochester Presbyterian Home	Thurston Rd., Rochester
• St. Johns	Johnsarbor Dr., Rochester
• Woodcrest Commons	West Henrietta Rd., Henrietta

Skilled Nursing Facilities

• Aaron Manor	St. Camillus Way, Fairport
• Brightonian	Elmwood Ave., Rochester
• Friendly Home	East Ave., Brighton
• Highlands Living Center	Hahnemann Trail, Pittsford
• Hurlbut	E. Henrietta Rd., Rochester
• Monroe Community Hospital	E. Henrietta Rd., Rochester
• M.M. Ewing	350 Parrish St., Canandaigua
• Penfield Place	Penfield Rd., Penfield
• Wedgewood	Church St., Spencerport

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Guidelines to Help You Along the Registration Pathway

Page 5: Ethnicity & Race Form

- ❑ Please share your ethnicity and race to help us to know our patients better and improve health care for all.

Page 6: Registration Document Form

- ❑ Complete patient name, date of birth, social security number, and facility address.
- ❑ Please supply us with a copy of your insurance card information.
- ❑ Indicate whether you will be handling your financial affairs or specify a responsible party.
- ❑ Designate an emergency contact.
- ❑ We also recommend a copy of the Power of Attorney and Health Care Proxy paperwork.
- ❑ Sign and date.

Page 7: Involvement in Care Discussion Form

- ❑ Use this form to appoint an individual with whom you would like us to share information, including appointment dates, lab draws, etc.
- ❑ Provide contact information for this individual.
- ❑ Sign and date.

Pages 8: Telehealth Consent Form

- ❑ Complete this form if you wish to be able to visit your health care team using video calls and similar.

Pages 9: Health History Form

- ❑ To the best of your knowledge, provide a brief description of your previous and current health, family, and social history.

Page 10: Authorization for Release of Medical & Behavioral Information Form

The authorization for release of medical and behavioral information form must be completed and signed in order for us to obtain previous medical records.

- ❑ Provide your current primary care physician's information with the doctor's name, address, and phone number to obtain your medical records. The review of your prior medical records is important to ensuring high-quality medical care. We encourage you/your family to help with this process.
- ❑ Sign and date.

Page 11: Change In Primary Care Provider Form

- ❑ If you are a participant in the Excellus Blue Cross/Blue Shield or MVP (Preferred Care) program, please sign this last form to update the change of your primary care physician for billing purposes.

Page 12-13: Questions About Health Care Costs

- ❑ This tip sheet addresses many common questions about health care costs to help you better understand potential expenses while receiving care at UR Medicine.

Page 14: Registration Completion Checklist

We are focused on providing excellent primary medical care for the elderly with excellent support for their families. Our office is staffed with many medical professionals to answer all of your questions and concerns Monday – Friday, 8:30 a.m. until 4 p.m.

Our team of medical providers is available through an on-call service 24 hours a day/7 days a week for medical emergencies during non-office hours.

We thank you again and look forward to providing you with the very best care.

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Ethnicity & Race Form

DATE _____

PATIENT'S NAME _____
FIRST MIDDLE LAST

BIRTH DATE _____ MEDICAL RECORD NUMBER _____
OFFICE USE ONLY

We are asking our patients to share their ethnicity and race. This will help us to know our patients better and improve health care for everyone. Personal information will remain private and confidential.

Ethnicity: Your ethnicity refers to your background heritage, culture, religion, ancestry or sometimes the country where you were born. For New York State reporting, we are specifically collecting whether or not your ethnicity is Hispanic, Latino, or of Spanish Origin.

Race: Your race is the group(s) that you relate to as having similar features, traits, or birthplace.

What is your ETHNICITY?

❑ **Hispanic** or **Latino** or **Spanish Origin** (If checked, please select up to 4 choices below):

- ❑ Andalusian
- ❑ Argentinean
- ❑ Asturian
- ❑ Belearic Islander
- ❑ Bolivian
- ❑ Canal Zone
- ❑ Canarian
- ❑ Castillian
- ❑ Catalonian
- ❑ Central American
- ❑ Central American Indian
- ❑ Chicano
- ❑ Chilean
- ❑ Colombian
- ❑ Costa Rican
- ❑ Criollo
- ❑ Cuban
- ❑ Dominican
- ❑ Ecuadorian
- ❑ Gallego
- ❑ Guatemalan
- ❑ Honduran
- ❑ La Raza
- ❑ Latin American
- ❑ Mexican
- ❑ Mexican American
- ❑ Mexican American Indian
- ❑ Mexicano
- ❑ Nicaraguan
- ❑ Panamanian
- ❑ Paraguayan
- ❑ Peruvian
- ❑ Puerto Rican
- ❑ Salvadoran
- ❑ South American
- ❑ South American Indian
- ❑ Spaniard
- ❑ Spanish Basque
- ❑ Uruguayan
- ❑ Valencian
- ❑ Venezuelan

❑ **Not Hispanic or Latino or Spanish Origin**
❑ **Patient Refused**

What is your RACE? (You may select up to 4 Races)

❑ **American Indian or Alaska Native**
❑ **Asian** (If checked, please specify from the choices below):

- ❑ Asian Indian
- ❑ Bangladeshi
- ❑ Bhutanese
- ❑ Burmese
- ❑ Cambodian
- ❑ Chinese
- ❑ Filipino
- ❑ Hmong
- ❑ Indonesian
- ❑ Iwo Jiman
- ❑ Japanese
- ❑ Korean
- ❑ Laotian
- ❑ Madagascar
- ❑ Malaysian
- ❑ Maldivian
- ❑ Nepalese
- ❑ Okinawan
- ❑ Pakistani
- ❑ Singaporean
- ❑ Sri Lankan
- ❑ Thai
- ❑ Taiwanese
- ❑ Vietnamese

❑ **Black or African-American**
❑ **Native Hawaiian or Pacific Islander** (If checked, please specify from the choices below):

- ❑ Carolinian
- ❑ Chamorro
- ❑ Chuukese
- ❑ Fijian
- ❑ Guamanian
- ❑ Guamanian or Chamorro
- ❑ Kiribati
- ❑ Kosraean
- ❑ Mariana Islander
- ❑ Marshallese
- ❑ Melanesian
- ❑ Micronesian
- ❑ Native Hawaiian
- ❑ New Hebrides
- ❑ Other Pacific Islander
- ❑ Pakistani
- ❑ Palauan
- ❑ Papua New Guinean
- ❑ Pohnpeian
- ❑ Polynesian
- ❑ Saipanese
- ❑ Samoan
- ❑ Solomon Islander
- ❑ Tahitian
- ❑ Tokelauan
- ❑ Tongan
- ❑ Yapese

❑ **White**
❑ **Other**
❑ **Patient Refused**

Registration Form

PATIENT'S INFORMATION

NAME _____ DATE OF BIRTH _____ MALE/FEMALE

ADDRESS _____ CITY _____ STATE/ZIP _____

PHONE # _____ SOCIAL SECURITY # _____

NAME YOU PREFER TO BE CALLED _____ FACILITY NAME _____

MARITAL STATUS: Single Married Divorced Separated Widowed

SPOUSE'S NAME _____ SPOUSE'S CONTACT # _____

INSURANCE INFORMATION
Please supply us with a copy of your Insurance Card

Insurance Name	Subscriber	Relationship to Subscriber	Member ID	Copay
1.				
2.				
3.				

RESPONSIBLE PARTY (Send bills to):

NAME _____ HOME # _____ WORK # _____

ADDRESS _____ CITY _____ STATE/ZIP _____

Are you Power of Attorney: Yes/No (If yes, please supply us with a copy of the paperwork)

CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ HOME # _____

ADDRESS _____ CITY _____ STATE/ZIP _____

Authorization of Medical Information Release and Payment Responsibility

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment. I acknowledge responsibility for payment of fee for all services rendered, regardless of any insurance coverage.
Medicare will only pay for services that it determines to be medically necessary. Under section 1862(a) (1) of the Medicare law it states that if the service is not necessary under Medicare program standards, payment will be denied. I have been notified that Medicare is likely to deny payment for my early physical, which Medicare considers preventative care and may not cover. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Please sign below to indicate consent to the statements above:

Signature: _____ Date: _____

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Involvement in Care Discussion Form

UR Medicine Geriatrics Group may discuss protected health information, including lab/test results and payment issues with the following people:

Name	Relationship	Phone Number

Communication Requests: _____ Days: _____

Phone me using the following number: _____

Y	N	
___	___	May phone me at work
___	___	May leave messages on answering machine
___	___	Other: _____

This will remain in effect until notified differently by the above patient.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND RETURN TO THE ADDRESS ON PAGE 2 FOR MD REVIEW. FAILURE TO RETURN A COMPLETE PACKET COULD DELAY TRANSFER OF MEDICAL CARE.

PRESENT HEALTH

Describe general health compared to others the same age: __ Excellent __ Good __ Fair __ Poor

Have you fallen within the past year: __ Yes __ No

Have you recently (within the last year) lost interest or pleasure in doing activities: __ Yes __ No

Have you recently (within the last year) felt down, depressed, and/or hopeless: __ Yes __ No

General health over the past 5 years: _____

_____

Weight changes: Past 6 months _____ Past year _____

Describe typical day/hobbies: _____

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Telehealth Consent

SH 419TELE MR

Highland Hospital • Strong Memorial Hospital

This consent is for all telehealth services provided for the following condition(s):

1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate my health condition.

2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission of my health information such as radiologic images, photos and sounds will be used during this appointment/ consultation and it will not be the same as a direct patient / health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor's office or other source of in-person care.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment/ consultation and thus will have the right to request the following:

(a) Omitting specific details of my medical history / physical examination that are personally sensitive;

(b) Asking non-medical personnel to leave the telemedicine examination room; and/ or

(c) Terminating the consultation at any time.

5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in a telehealth appointment/consultation, I understand that some parts of the visit, such as the physical exam, may be conducted by individuals at my location at the direction of the consulting health care provider, as indicated.

6. In an **emergent** consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that depending on factors such as my location, my health insurance, and the services I am receiving, billing may occur from both my health care provider and the facility at which I am presenting for my appointment. If my health insurance is Medicaid and I am receiving telepsychiatry services in a location that is licensed by the New York State Office of Mental Health, I understand that billing will only occur from the facility at which I am presenting.

8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment / consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment / consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature	Date	Time

TO BE COMPLETED BY STAFF

No signature was obtained due to:

❍ Impractical, verbal consent given

❍ Patient's condition/capacity

❍ No representative

Staff Signature	Date	Time

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Functional Status & Health History

HEALTH HISTORY

Surgeries

Date	Diagnosis/Condition

Date	Diagnosis/Condition

SOCIAL HISTORY

Education: _____ Occupation: _____

Religion: _____ Children/Grand Children: _____

Does someone else depend on you as a caregiver? _____

FAMILY HISTORY

Mother: Age of death: _____ Cause of death: _____

Father: Age of death: _____ Cause of death: _____

Siblings: Age of death: _____ Cause of death: _____

Siblings: Age of death: _____ Cause of death: _____

HABITS

Alcohol intake: _____ Have you used street drugs: _____

Smoking History: _____ Do you exercise regularly: _____

ADVANCE DIRECTIVES

Do you have a Health Care Proxy? Y/N Name: _____

Do you have a Living Will? Y/N

Do you have a MOLST Form? Y/N

Please provide copies of the above documents if available.

Person Completing this Form: _____ Relationship: _____

If someone other than the patient is completing this form, a copy of the Power of Attorney form is required

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Authorization for Release of Medical & Behavioral Information

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PHONE # _____ SOCIAL SECURITY # _____

DATE OF REQUEST: _____ DATE NEEDED: _____

I authorize UR Medicine Geriatrics Group to obtain information from:

NAME OF PROVIDER or FACILITY _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PHONE #/FAX # (Include Area Code) _____

Purpose for this request: ❑ Health Care ❑ Insurance Coverage ❑ Personal ❑ Other

Type of Records Requested: ❑ Inpatient: dates _____ ❑ Outpatient: dates _____

Specific Information (Select one or more, as applicable)

❑ Operative Report ❑ History & Physical ❑ Discharge Summary ❑ Laboratory Tests

❑ X-Ray Reports ❑ Physical Therapy ❑ Other: _____

❑ Treatment Summary (Includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

❑ Copy of the entire inpatient/outpatient record checked above

Authorization Valid For: (Check one)

❑ This request only

❑ One year from the date of this authorization OR _____ (insert date).
This authorization applies to the records of the treatment received on or prior to the date of this authorization.

❑ This request is for medical records of any future treatment of the type described above until: _____

I understand that:

- My right to health care treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of the form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requestor is not the patient): _____

OFFICE USE ONLY

MAIL OR FAX:

UR Medicine Geriatrics Group
1870 S. Winton Road, Suite 100
Rochester, NY 14618

Fax: (585) 424-4184

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Change in Primary Care Provider Form

Insurance Company:

❑ Blue Choice	Fax # 238-3692	Attn: Member Services
❑ MVP (Preferred Care)	Fax # 327-2227	Attn: Member Services

PATIENT'S NAME _____

ADDRESS _____ CITY _____ STATE/ZIP _____

PHONE # _____ DATE OF BIRTH: _____

CONTRACT # _____

I would like to change my Doctor

FROM: _____

TO: _____

EFFECTIVE AS OF: _____

REASON: _____

_____

Signature: _____ Date: _____

_____ Provider ID #: _____ (Office use/MVP only)

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Questions About Health Care Costs

This tip sheet addresses many common questions about health care costs to help you better understand potential expenses while receiving care at UR Medicine.

Thank you for entrusting your care to UR Medicine. We are committed to providing you with excellent service in all aspects of your care, including answering your questions about your health care costs. With more patients moving to newer high deductible and co-insurance plans, we find many patients have questions about medical expenses.

As part of our service excellence pledge to you, we are providing this tip sheet to make you aware of some of the ways you can better understand your potential expenses while receiving care at UR Medicine.

- **Become aware of your insurance plan's "network tiers"**

  Today, many insurance plans sort hospitals and other care providers into "in-network" and "out-ofnetwork" tiers. Typically, "in-network" care is less expensive than "out-of-network" care. Before you receive care, it's a good idea to contact your insurance company to help you understand how your health care providers' status in a particular tier may affect your health care costs.

- **UR Medicine care providers & hospitals**

  Most UR Medicine care providers and hospitals accept most insurance plans (see list on reverse side or visit *insurance.urmc.edu*). To find out if your care provider is part of the UR Medicine network, visit *urmc.rochester.edu/people/*. You can also view the specific locations where your UR Medicine care provider works at *urmc.rochester.edu/people/*. UR Medical Faculty have admitting privileges to Strong Memorial Hospital, Highland Hospital or both.

- **Separate charges for some services**

  UR Medicine will send one combined bill for the health care services you received. The UR Medicine logo will be at the top of the Statement of Services. The bill will separate charges related to: [1] Hospital facility fees. These are fees which includes such items as exam/ surgery rooms, medicine given, x-rays taken, tests, etc. [2] Physician Fees. These fees are for a provider who was involved in your care in-person or reviewing images/tests, etc.

- **Referrals and insurance plans**

  When your care provider sends you to the hospital or arranges a procedure or test, ask your insurance company if those providers are "in network" for your plan. On our website, you can view a list of UR Medicine lab locations *(urmc.rochester.edu/urm-labs/service-centers.aspx)* and imaging locations *(urmc.rochester.edu/imaging/locations.aspx)*.

- **Anticipated costs at UR Medicine**

  You may contact our Health Care CostEstimator team at 585-758-7801 to receive an estimated cost for services or procedures provided at UR Medicine hospitals or by our providers.

- **Financial assistance is available**

  UR Medicine also offers a Financial Assistance program for individuals who cannot afford the health care they need.

For more information, visit: *financialassistance.urmc.edu* or call 585-784-8889.

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Last Updated: 4/22/24

Insurance Carriers

Below is a list of the insurance carriers that UR Medicine care providers and hospitals serve as participating providers. Each carrier may offer several different plans. UR Medicine doctors and hospitals routinely care for patients served by a variety of health plans and the participation status with each plan is unique. While a specific health plan may not be listed here, your UR Medicine provider may participate. Please contact your insurance carrier to learn if your particular plan is accepted by UR Medicine, and the services you require are covered under your plan.

	Provider	Facility	Facility	Provider	Facility	
Health Insurance Carrier	**UR Medicine Care Providers**	**Strong Memorial Hospital**	**Highland Hospital**	**UR Medicine Behavioral Health Services Care Providers**	**UR Medicine Behavioral Health/Strong Memorial Hospital**	**Contact Information**
Aetna including Medicare	Yes	Yes	Yes	Yes	Yes	aetna.com
Beacon Health Options	Yes	Yes	**No**	Yes	Yes	beaconhealthoptions.com
BlueCross and BlueShield of Western New York including Medicare Plans	Yes	Yes	Yes	Yes	Yes	bcbswny.com
BlueCross BlueShield of Western New York Medicaid Plans	Yes	Yes	Yes	Yes	Yes	mybcbswny.com
CIGNA	Yes	Yes	Yes	**No**	**No**	cigna.com
Elderplan	Yes	Yes	Yes	Yes	Yes	elderplan.org
EmblemHealth (GHI)	Yes	Yes	Yes	Yes	Yes	emblemhealth.com
The Empire Plan	Yes	Yes	Yes	Yes	Yes	empireplanproviders.com
Excellus BlueCross and BlueShield including Medicare Plans and Medicaid Plans	Yes	Yes	Yes	Yes	Yes	excellusbcbs.com
Fidelis Care	Yes	Yes	Yes	Yes	Yes	fideliscare.org
Fidelis Care Medicare	**No**	**No**	**No**	**No**	**No**	fideliscare.org
GWH-CIGNA	Yes	Yes	Yes	Yes	**No**	cigna.com
iCircle Care	Yes	Yes	Yes	Yes	Yes	icirclecarecny.org
Independent Health including Medicare	Yes	Yes	Yes	Yes	Yes	independenthealth.com
Independent Health Medicaid/MediSource Plans	Yes	Yes	Yes	Yes	Yes	independenthealth.com
MagnaCare	Yes	Yes	Yes	Yes	**No**	magnacare.com
Martin's Point (US Family Health Plan)	Yes	**No**	**No**	Yes	**No**	martinspoint.org
Medicaid – New York State*	Yes	Yes	Yes	Yes	Yes	health.ny.gov/health_care/medicaid/
Medicare*	Yes	Yes	Yes	Yes	Yes	medicare.gov
MultiPlan / PHCS	Yes	Yes	Yes	Yes	**No**	multiplan.com
MVP Health Care including Medicare Plans and Medicaid Plans	Yes	Yes	Yes	Yes	Yes	mvphealthcare.com
OptumHealth Behavioral Soultions / United Behavioral Health	Yes	Yes	**No**	Yes	Yes	liveandworkwell.com
POMCO/UMR	Yes	Yes	Yes	Yes	Yes	umr.com
TRICARE*	Yes	Yes	Yes	Yes	Yes	tricare.mil
UnitedHealthcare	Yes	Yes	Yes	Yes	Yes	uhc.com
UnitedHealthcare Community Plan Medicaid Plans	Yes	Yes	Yes	Yes	Yes	uhccommunityplan.com
Univera Healthcare including Medicare	Yes	Yes	Yes	Yes	Yes	univerahealthcare.com
Veterans Affairs Community Care Network (VA CCN)	Yes	Yes	Yes	**No**	**No**	va.gov
YourCare	Yes	Yes	Yes	Yes	Yes	yourcarehealthplan.com

*Government-funded plan accepted by UR Medicine

Last Updated: 2/2020

Registration Completion Checklist

****Below is a list of all the information that is required for the packet to be processed. Any missing information will prevent registration****

- ❑ Copy of completed 3122
- ❑ Medication List
- ❑ Insurance information, including copy of insurance card(s)
- ❑ Copy of Power of Attorney paperwork (if someone other than the patient is signing)
- ❑ Signatures on pages 6, 9, 10
- ❑ Packet completed with all requested information (blank packets will be sent back to be completed)

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