Amalgamated Medical Care Management
Quality Clinical Advice & Care

1 Northeastern Blvd.
Suite 100
Salem, NH 03079

CASE MANAGEMENT CONSENT & AUTHORIZATION

I hereby authorize Amalgamated Medical Care Management to provide Case Management services to me. I understand this is a benefit offered to me through my insurance plan at no cost to me.

I consent to Amalgamated Medical Care Management to discussing, reviewing and providing to my healthcare providers, information concerning my health care condition and treatment needs. This information will be used solely for the purpose of determination of medical necessity of treatment and services. All information provided to or obtained by the Case Manager during this evaluation will be held confidential.

I understand that this authorization is voluntary, and that I can call my health insurance plan if I do not want Case Management services, from Amalgamated Medical Care Management or from anyone.

PATIENT BILL OF RIGHTS

I have the right to be informed of choices related to available services of care.

I have the right to involvement in the case management plan.

I have the right to choose a friend, family member, or other person to act as my personal representative, and to speak with Amalgamated Medical Care Management on my behalf. I must notify Amalgamated Medical Care Management of this choice in writing.

I have the right to be made aware of use of end of life and advance care directives.

I have the right to obtain information regarding the criteria for case closure.

I have the right to receive notification and a rationale when case management services are changed or terminated.

I have the right to alternative approaches when I and/or my family are unable to participate in the assessment phase.

I have the right to receive a copy of this consent form upon request and agree that a photographic copy of this authorization is as valid as the original. This consent is valid for one year, unless otherwise indicated.

I have the right to call Amalgamated Medical Care Management at (800) 863-8688 with any questions that I have, at any time.

By signing below, I affirm that I have read and understand the Case Management Consent and Patient Bill of Rights.

Print Name of Patient	Signature of Patient or Authorized Representative	Date

***If signed by an authorized representative, print your name and indicate your relationship to the patient below:

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