HEALTHCARE ACCESS ISSUE REPORT FOR PATIENTS WITH BLEEDING DISORDERS

Privacy Notice: Your identity will not be disclosed to any other individuals, groups or organizations outside of HCC without your express written permission. Please submit report at healthaccess@hemophiliaca.org or mail.

Patient Name: ____ Age: _______ Gender: M F
(optional)

Patient's county of residence: ________________________________

Bleeding disorder: Hemophilia von Willebrand disease Other (please specify) ____________________________

Type of insurance: Medi-Cal CCS GHPP Medicare

Private (name of carrier): __________________________________ Don't know

Who is completing this report? Patient Parent Caregiver HTC staff member

Chapter Specialty pharmacy representative Other (please specify) ________________________________

Name of medical facility where problem occurred: ____
(optional)

Physician name (optional): ____

Best way to contact you if more information is needed (optional):

Email: ____ Phone: __________________________

PROBLEM INFORMATION

Date problem(s) began: _________________ Type of Problem: HTC access Medication approval

Choice of specialty pharmacy Other ____

Describe problem (Please leave first word in the form fields below to retain formatting.)

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HEMOPHILIA COUNCIL OF CALIFORNIA

What steps have been taken to resolve the problem(s)?

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Was there a resolution to the problem(s)? Please specify if there has been a complete or partial resolution and list any problems that still exist.

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Additional comments?

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