Your Health Plan Information and Contacts

If You Have Medicare:

___ Original
___ Part D Plan (prescription drugs)
Part D Plan Name: ________________________
Or
___ Medicare Advantage Plan
Medicare Advantage Plan Name: ________________________

Community HealthChoices (CHC) Plan:

___ Keystone First CHC
   AmeriHealth Caritas PA CHC
Keystone First CHC Participant Services: 1-855-332-0729
   (TTY: 1-855-235-4976)

___ PA Health & Wellness
Participant Services: 1-844-626-6813  (TTY: 1-844-349-8916)

___ UPMC CHC
Participant Services: 1-844-833-0523  (TTY: 711)

Primary Care Physician (PCP)
Name: ________________________
Phone: ________________________

Other Doctor/Specialist
Name: ________________________
Phone: ________________________

Pharmacy
Name: ________________________
Phone: ________________________

Behavioral HealthChoices Plan
Name: ________________________
Phone: ________________________
If You Get Long Term Services and Supports (LTSS) From Your CHC Plan

“LTSS” means getting help with daily living activities, such as: dressing, bathing, managing medications, and more. If you need help, or more help, taking care of yourself at home or need nursing home care, call your CHC plan or service coordinator.

Service Coordinator
Name: ____________________________
Phone: ____________________________
Agency: ___________________________

Personal Care Aide/Helper
Name: ____________________________
Phone: ____________________________
Agency: ___________________________

Personal Care Aide/Helper
Name: ____________________________
Phone: ____________________________
Agency: ___________________________

Transportation
MATP Name: _______________________
Phone: ____________________________
Other Provider: _____________________
Phone: ____________________________

Counselor
Name: ____________________________
Phone: ____________________________
Agency: ___________________________

Adult Day Program
Center Name: ______________________
Social Worker: _____________________
Phone: ____________________________

Nursing Home
Facility Name: _____________________
Social Worker: _____________________
Phone: ____________________________
**Other Contacts**

List other people who are important to you and your care.

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