MY BENEFITS

Transition of Care Forms

Transition Coverage Request

Personal & Confidential

This form does not apply to fully insured commercial members in California

(See other side for Transition-of-Care coverage questions and answers)

This is a formal request for Aetna to cover ongoing care at the preferred or the highest level of benefit from:

- An **out-of-network doctor;** or
- A **doctor whose Aexcel or integrated delivery system [IDS] home host network status has changed**; or
- **Certain other health care providers** who have treated you.

You will receive a coverage decision by mail. If coverage is not approved, care by the doctor or other health care provider you chose:

- Will not be covered after the plan's effective date; **or**
- Will not be covered after the date of the doctor's Aexcel or IDS home host network status change **or**
- Will not be covered after the end of the provider's contract with the Aetna network; **or**
- Will be covered at the nonpreferred rate or the lowest in-network rate.

Step 1: Patient: Please complete:

1. Section 1 (employer information)
2. Section 2 (subscriber and patient information —found on the front of the Aetna ID card)
3. Section 3 (authorization) Read the authorization, sign and date the form (if patient is age 17 or older, he or she must also sign and date this form).

Step 2: Give the form to the doctor to complete Section 4 (doctor information).

Step 3: **Fax** the completed form to Aetna for review. Please note: Complete one form for each out-of-network provider.

*Transition of Coverage **does not** apply to Aetna's in-network (participating) providers. To find out if your doctor is in the network, or for help finding a participating provider for your Aetna plan, please go to DocFind, our online provider directory, at **www.aetna.com**, or contact Member Services at the number on your Aetna ID card. **Fax numbers:**

Fax medical requests to: 1-800-228-1318

Fax mental health/drug/alcohol abuse requests to: 801-256-7679

To speed up your transition coverage request, please complete all fields below when submitting this form.

1. Employer Information

Employer's Name (Please print)	Plan Control Number	Plan Effective Date (**Required**)

2. Subscriber and Patient Information

Subscriber's Name (Please print)	Subscriber's Aetna Identification Number (or Social Security Number)	
Subscriber's Address (Please print)		
Patient's Name (Please print)	Birthdate *(MM/DD/YYYY)*	Telephone Number
Patient's Address (Please print)	Plan Type/Product	

3. Authorization

I request approval for coverage of ongoing care from the health care provider named below for treatment started before my effective date with Aetna, or before the end of the provider's contract with the Aetna network, or before the provider's Aexcel or IDS network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain period of time. I give permission for the health care provider to send any needed medical information and/or records to Aetna so a decision can be made.

Patient's Signature (**Required** if patient is age 17 or older)	Date *(MM/DD/YYYY)*
Parent's Signature (**Required** if patient is age 16 or younger)	Date *(MM/DD/YYYY)*

4. Doctor Information - Please provide all specific information to avoid delay in the processing of this request.

Name of treating doctor or other health care provider (Please print)	Telephone Number
Address of treating doctor or other health care provider (Please print)	
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

The above-named patient is currently an Aetna member as of the effective date indicated above. Although you are not or soon will not be a participating provider in the plan network, or your Aexcel/IDS home host network status has changed, the patient has asked that we cover care provided by you for a specific period of time because of a condition requiring an active course of treatment (for example, pregnancy). An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation." Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If this request is approved, you agree to provide the patient's treatment and follow up; to not seek payment from the patient for any amount other than any applicable patient copayment, deductible or coinsurance, or, with respect to Open Choice members only, any amount deemed not payable by the plan; to share information regarding the treatment plan with Aetna; and to use the Aetna provider network for any necessary referrals, lab work or hospitalizations.

Please list diagnosis, specific treatment, start date of treatment, and dates of current or future treatment.

Diagnosis (including ICD-9 codes)	Treatment (include related codes)	Start Date of Treatment	Dates of Current and Anticipated Treatment
1.			
2.			

Aetna Transition-of-Care Coverage Questions and Answers

Q. What is transition-of-care (TOC) coverage?

A. TOC coverage is temporary coverage you can receive when you become a new member of an Aetna medical benefits plan or change your current Aetna medical plan, and a doctor you are being treated by:

- Is not in the Aetna network or;
- Leaves the Aetna network or;
- Changes Aexcel or integrated delivery system (IDS) home host status, which affects your benefits, or
- Is not included in Aexcel or the IDS home host network and your benefits change to include one of these networks.

TOC coverage is not for primary care physicians (PCPs) who are not in the Aetna network, except when the PCP leaves the Aetna network during your plan year, and you are receiving treatment, or if certain laws or regulations apply. TOC coverage allows a member who is receiving treatment to continue the treatment ***for a limited time*** at the preferred plan benefit level.

TOC coverage is only for the requested doctor and does not include facilities or hospitals. If the request is approved, the doctor must use a facility or hospital in the Aetna network.

Q What is an active course of treatment?

A. An active course of treatment is when you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some examples may include, but are not limited to:

- Members who enroll with Aetna beyond 20 weeks of pregnancy (unless there are specific state or plan requirements). Members less than 20 weeks pregnant whom Aetna confirms as high risk are reviewed on a case-by-case basis.
- Members in an ongoing treatment plan, such as chemotherapy or radiation therapy.
- Members with a terminal illness who are expected to live six months or less.
- Members who need more than one surgery, such as cleft palate repair.
- Members who have recently had surgery.
- Members who receive outpatient treatment for a mental illness or for substance abuse. (The member must have had at least one treatment session within 30 days before the effective/renewal date of the Aetna plan.)
- Members with an ongoing or disabling condition that suddenly gets worse.
- Members who may need or have had an organ or bone marrow transplant.

To be considered for TOC coverage, the course of treatment must have started before the enrollment or re-enrollment date, or *before* the date your doctor left the Aetna network, or *before* the date of a doctor's Aexcel or IDS Home Host network status change.

Q. What other types of providers, besides doctors, can be considered for TOC coverage?

A. Health care professionals such as physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services such as visiting nurses. TOC does not apply to durable medical equipment (DME) vendors, health care facilities (for example, hospital, skilled nursing facility) or pharmacy vendors.

Q. If I am currently receiving treatment from my doctor, why wouldn't my request be approved for TOC coverage?

A. In addition to currently receiving treatment, your request must involve a covered procedure/service. Your doctor must also agree to accept the terms outlined on the TOC Request Form.

Q. My PCP is no longer an Aetna provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you are currently receiving treatment, you may still be able to visit your PCP, even if they leave the network. In all states except Texas and New Jersey, you may need to select a PCP in the Aetna network. In Texas and New Jersey, TOC may apply to PCPs. Talk to your PCP so that he/she can help you with your future health care needs.

Q. How long does TOC coverage last?

A. Usually, TOC coverage lasts 90 days but this may vary based on your condition (for example, pregnancy). You will be informed if your TOC coverage request is approved and how long it will last.

Q. How do I sign up for TOC coverage?

A. Contact your employer or Aetna Member Services. You must submit a TOC Request Form to Aetna:

- Within 90 days of when you enroll or re-enroll, or
- Within 90 days of the date the provider left the Aetna network, or
- Within 90 days of a doctor's Aexcel or IDS home host network status change.

You or your doctor can send in the request form.

Q. How will I know if my request for TOC coverage is approved?

A. You will receive a letter in the mail. The letter will say whether or not you are approved. .

Q. Does TOC coverage apply to the Traditional Choice Plan?

A. No. This plan does not have a provider network.

Q. What if I have an Aexcel or IDS plan?

A. If TOC coverage is approved, you may still receive care at the highest benefit level for a certain time period. If you continue treatment with a doctor who is not part of the Aexcel/IDS home host network, or a doctor whose Aexcel/IDS home host network status changes after the approved time period, your coverage would follow what is stated in your plan design. This means you may have reduced benefits or no benefits.

Q. If I have additional questions about TOC, who can I contact?

A. You can call the Member Services number on your Aetna ID card. If you have questions about TOC mental health services, you can call the Member Services number on your Aetna ID card or, if listed, the mental health or behavioral health number.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Arkansas, Louisiana, and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits

TRANSITION OF CARE
CONTINUITY OF CARE

See how they work

What is Transition of Care?

With Transition of Care, you may be able to continue to receive services for specified medical conditions with health care professionals who are not in the Cigna network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network doctor or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your Cigna medical plan. You must apply no later than 30 days after the effective date of your coverage.

What is Continuity of Care?

With Continuity of Care, you can receive services at in-network coverage levels for specified medical conditions when your health care professional leaves your plan's network. There must be clinical reasons preventing immediate transfer of care to another health care professional. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care professional's termination date. This is the date that he or she is leaving your plan's network.

How they both work

- You must already be under treatment for the condition identified on the Transition of Care/ Continuity of Care request form.
- If the request is approved for medical conditions, please note:
  - The level of coverage for the treatment of the specific condition will be defined in your policy/ service agreement or plan documents. If you have questions regarding coverage and potential responsibility for charges, please discuss this with the case manager assigned to you (if you do not have a case manager, please call Cigna directly).
  - Your plan may not include out-of-network coverage. If that is the case, and you choose to continue care out-of-network beyond the time frame approved by Cigna, you may not have coverage for those services. Please check your plan documents for covered and non-covered services.
  - Transition of Care/Continuity of Care applies only to the treatment of the medical condition specified and the health care professional identified on the request form. (All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage.)
- The availability of Transition of Care/Continuity of Care:
  - Does not guarantee that a treatment is medically necessary.
  - Does not constitute precertification of medical services to be provided.
- Depending on the actual request, a medical necessity determination and formal precertification may still be required for a service to be covered.

Important note: In Virginia, Tennessee and Missouri, if your request is approved, you may still owe more than if you went to an in-network provider.

Together, all the way.®

Cigna®

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Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy in the second or third trimester at the time of the plan **effective date** of coverage or of the health care professional termination.
- Pregnancy is considered 'high risk' if mother's age is 35 years or older, or patient has/had:
  - Early delivery (three weeks) in previous pregnancy.
  - Gestational diabetes.
  - Pregnancy induced hypertension.
  - Multiple inpatient admissions during this pregnancy.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period, that is generally six to eight weeks.
- Acute conditions in **active treatment** such as heart attacks, strokes or unstable chronic conditions.
  - "**Active treatment**" is defined as a doctor visit or hospital stay with documented changes in a therapeutic regimen. This is within 21 days prior to your plan effective date or your health care professional's termination date.
- Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).

Examples of conditions that do not qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Routine exams, vaccinations and health assessments.
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma.
- Acute minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries such as removal of lesions, bunionectomy, hernia repair and hysterectomy.

What time frame is allowed for transitioning to a new in-network health care professional?

If Cigna determines that transitioning to an in-network health care professional is not recommended or safe for the conditions that qualify, services by the approved out-of-network health care professional will be authorized for a specified period of time (usually 90 days). Or, services will be approved until care has been completed or transitioned to an in-network health care professional, whichever comes first.

If I am approved for Transition of Care/Continuity of Care for one illness, can I receive in-network coverage for a non-related condition?

Authorizations provided as part of Transition of Care/Continuity of Care are for the specific illness or condition only and cannot be applied to another illness or condition. You need to complete a Transition of Care/Continuity of Care request form for each unrelated illness or condition. You need to complete this form no later than 30 days after your plan becomes effective or your health care professional leaves the Cigna network/your plan's network.

Can I apply for Transition of Care/Continuity of Care if I am not currently in treatment or seeing a health care professional?

You must already be in treatment for the condition that is noted on the Transition of Care/Continuity of Care request form.

How do I apply for Transition of Care/Continuity of Care coverage?

Requests must be submitted in writing, using the Transition of Care/Continuity of Care request form. This form must be submitted at the time of enrollment, change in Cigna medical plan, or when your health care professional leaves the Cigna network/your plan's network. It cannot be submitted more than 30 days after the effective date of your plan or your health care professional's termination. After receiving your request, Cigna will review and evaluate the information provided. Then, we will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

Cigna Transition of Care/Continuity of Care request form

See instructions for completing this form on the reverse side.

❑ New Cigna enrollee (Transition of Care applicant)

❑ Existing Cigna customer whose health care professional terminated (Continuity of Care applicant)

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Enrollment in Cigna Plan (mm/dd/yyyy)			
Full Name		Social Security # or Alternate ID	Work Phone
Home Address Street City State ZIP			Home Phone/Mobile
Patient's Name (if applicable)	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship ❑ Spouse ❑ Dependent ❑ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date _____(mm/dd/yyyy) ❑ Yes ❑ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ❑ Yes ❑ No
3. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Cigna? ❑ Yes ❑ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
6. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ❑ No
7. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
8. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
9. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

_____

10. Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name		Health Care Professional Phone #
Health Care Professional Specialty		
Health Care Professional Address		
Hospital Where Health Care Professional Practices		Hospital Phone #
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when coverage with Cigna begins or during the next 90 days? ❑ Yes ❑ No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care, you need to complete a separate Transition of Care/Continuity of Care form.

_____

I hereby authorize the above health care professional to give Cigna or any affiliated Cigna company any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care under Cigna. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive, Pittsburgh, PA 15275
Fax 866.729.0432

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt. For new Cigna customers, review will occur within 10 days of participant's effective date. Review for Organ Transplant requests may take longer than 10 days.

Instructions for completing the Transition of Care/Continuity of Care request form

A separate Transition of Care/Continuity of Care request form must be completed for each condition for which you and/or your dependents are seeking Transition of Care/Continuity of Care. Additional forms are available on **Cigna.com**. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Transition of Care/Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.

To help ensure a timely review of your request, please return the form as soon as possible. You must apply for Transition of Care/Continuity of Care within 30 days of the effective date of your plan, or within 30 days of your doctor's termination date.

The first few sections of the form apply to the subscriber. When the form asks for the patient's name, enter the name of the person who is receiving care and is requesting Transition of Care/Continuity of Care.

If you answered yes to questions #1, #2, #3, #4, #5, #6, #7 or #8, please submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive
Pittsburgh, PA 15275
Fax: 866.729.0432

In #9, include information about the current or proposed treatment plan and the length of time treatment is expected to continue. If surgery has been planned, state the type and the proposed date of the surgery.

In #12, briefly state the health condition, when it began, what health care professional is currently involved, and how often you see this health care professional. Please be as specific as possible.

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt. For new Cigna customers, review will occur within 10 days of participant's effective date. Review for Organ Transplant requests may take longer than 10 days.

How Transition of Care and Continuity of Care works:

You must already be under active and current treatment (see definition below) by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity of Care form below.

Your request will be evaluated based on applicable Federal law, plan benefits and accreditation standards. Coverage at the network level is available if the provider agrees to accept our network rates, provide medical records, follow our policies and a treatment plan approved by us.

- If your request is approved for the medical condition(s) listed in your form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for:
    - Up to 30 days from the effective date of coverage for new members,
    - Up to 90 days from when your provider leaves your health plan network, or
    - through completion of the current active course of treatment period, whichever comes first
- After this time, network coverage ends. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame we approve, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements.
- All other services or supplies must be provided by a network health care professional for you to receive network coverage levels.
- If your plan does not include out-of-network coverage, you can call the number on the back of your health plan ID card for assistance.
- The availability of Transition of Care and Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

Examples of medical conditions that may qualify for Transition of Care and Continuity of Care includes, but is not limited to:

- Pregnant and undergoing a course of treatment for pregnancy.
  – Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select an in network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery).
- Serious acute conditions in active treatment such as heart attacks or strokes.
- Other serious chronic conditions that require active treatment.

Examples of conditions that do not qualify for Transition of Care and Continuity of Care include:

- Routine exams, vaccinations and health assessments.
- Chronic conditions such as diabetes, arthritis, allergies, asthma, kidney disease and hypertension that are stable.
- Minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries.

Frequently asked questions:

Q What can I expect after the completed form is submitted?

A You will receive a written decision either approving or denying your request. We encourage you to find a doctor, health care professional or facility (like a hospital) in your network at myuhc.com.

Q If I am approved for Transition of Care and Continuity of Care for one medical condition, can I receive network coverage for a non-related condition?

A No. Network coverage levels provided as part of Transition of Care and Continuity of Care are for the specific medical conditions only and cannot be applied to another condition. If you are seeking network level of benefits for more than one medical condition, you will need to complete a separate request for each specific condition.

Definitions:

Transition of Care: Gives new UnitedHealthcare members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition, until the safe transfer to a network health care professional can be arranged.

Continuity of Care: Gives UnitedHealthcare members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Out-of-network: Services provided by a non-participating provider.

Pre-authorization: An assessment for coverage under your health plan before you can get access to medicine or services.

Active course of treatment: An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally an active course of treatment is defined as within the last 30 days, but is evaluated on a case-by-case basis.

See other health care and health insurance terms and definitions at **justplainclear.com**.

Transition of Care and Continuity of Care Form

This form is for self-funded members only.

For behavioral health services, please contact your behavioral health carrier by calling the Customer Service phone number on your health plan ID card.

To complete this form:

- Please make sure all fields are completed. When the form is complete, it must be signed by the member for whom the Transition of Care and Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for Transition of Care and Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date.
- A separate Transition of Care and Continuity of Care form must be completed for each condition for which you and/or your dependents are seeking Transition of Care and Continuity of Care.
- Please mail or fax the completed form along with relevant medical records and information, within 30 days following the effective date of your UnitedHealthcare plan to:

UnitedHealthcare
600 Airborne Parkway
Cheektowaga, NY 14225
Attn: Transition of Care/Continuity of Care Fax: 855-686-3561

- After receiving your request, UnitedHealthcare will review and evaluate the information provided. Incomplete forms will be returned to the requestor. If the form is complete, we will send you a letter to let you know if your request was approved or denied. Completion of this form does not guarantee that a Transition of Care and Continuity of Care request will be granted.

Member Information

☐ New UnitedHealthcare member (Transition of Care applicant) ☐ Existing UnitedHealthcare member whose care provider terminated (Continuity of Care applicant)		Provider Termination Date
Name (Person being treated)	UnitedHealthcare Member ID Number	Date of Birth (mm/dd/yyyy)
Address	City	State/ZIP Code
Home/Cell Phone Number	Work Phone Number	
Employer Name	Date of Enrollment in the UnitedHealthcare Plan (mm/dd/yyyy)	
Member's Relationship to Employee ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Is the member currently covered by other health insurance carrier? ☐ Yes ☐ No If yes, carrier name:	

Authorization to release records:
I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Transition of Care/Continuity of Care benefits under the plan.

Member's Signature/Parent or Guardian's Signature if Member is a Minor	Date (mm/dd/yyyy)

Care Provider Section: Your health care professional should complete the following information.		
Name (Treating Physician or other Healthcare Professional)	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Facility Name, NPI or TIN, City and State		Facility Phone Number
Date of Last Visit (mm/dd/yyyy)	Next Scheduled Appointment (mm/dd/yyyy)	Frequency of Visits
Diagnosis	Expected Length of Treatment	If Maternity: Expected Date of Delivery (mm/dd/yyyy)

Please select 1 of the descriptions if it applies:

☐ Life-Threatening Condition ☐ Acute Condition ☐ Transplant ☐ Inpatient/Confined
☐ Upcoming Surgery ☐ Disabled/Disability ☐ Terminal Illness ☐ Ongoing Treatment

Newborn members: Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select a network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

Is the treatment for an exacerbation of a previous injury or chronic condition? ☐ Yes ☐ No

Current Condition and Associated Treatment Plan (include brief statement and all relevant CPT codes)*
If these care needs are not associated with the condition for which you are requesting Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition. *attached additional clinical as needed.

We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time-frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered. Please note the following:

For providers leaving our network: The terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any co-payment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional Date (mm/dd/yyyy)

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.