

# TRANSITION OF CARE FORM

Please note that this information pertains to you and/or your dependents health care and is not intended for authorization of services.



If you are currently under the care of a non-network provider, there are a limited number of medical conditions that may qualify for Transition of Care. If transitional care is appropriate, specific treatment by a non-network provider may be covered at the network level of benefits for a limited period of time. These services are subject to eligibility and coverage limitations at the time the medical care is administered.

**This form must be submitted within 30 days of your new enrollment date.**

Please check box if this is dependent information.

<b>Employee Name:</b>	<b>DOB:</b>	<b>Employee ID#:</b>	
<b>Dependent Name:</b>	<b>DOB:</b>	<b>EPO</b>	<b>PPO</b>
<b>Day Time Phone: ( )</b>		<input type="checkbox"/> Aetna	<input type="checkbox"/> Aetna
<b>Address:</b>		<input type="checkbox"/> BCBS of AZ	<input type="checkbox"/> BCBS of AZ
		<input type="checkbox"/> UHC	<input type="checkbox"/> UHC
		<input type="checkbox"/> Cigna	
		<b>Medicare Primary</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Primary Care Physician:</b>	<b>Phone: ( )</b>		
<b>Do you use any specialty injectable medication other than insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>			
If yes, please list:			
<b>Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.</b>			
<input type="checkbox"/> Elective Surgery <i>(Including transplant)</i>	Facility: Nature of Surgery:	Date:	Physician Name: Phone:
<input type="checkbox"/> Pregnancy	Due Date:		Physician Name: Phone:
<input type="checkbox"/> Radiation Oncology	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Chemotherapy	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Dialysis	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Outpatient Rehabilitation	Facility:	Date:	Physician Name: Phone:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiac Therapy
<input type="checkbox"/> Home Health Services	Agency Name:	<i>(Including skilled nursing)</i> Nature of Services:	
<input type="checkbox"/> Durable Medical Equipment	Vendor Name:	Please check all that apply:	
	<input type="checkbox"/> Catheter supplies	<input type="checkbox"/> CPAP	<input type="checkbox"/> Bed/Mattress
	<input type="checkbox"/> Ostomy supplies	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Wheelchair
			<input type="checkbox"/> Diabetic Supplies
Do you have any of the following diseases: <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> CHF			
<b>Do you have any health care concerns where you may need assistance from a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>			
Please explain:			
<b>Are you currently receiving mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>		<b>If yes, please provide the following:</b>	
Provider Name:	Provider Phone: ( )	Date of Next Appt:	
<b>Are you currently receiving substance abuse services: <input type="checkbox"/> Yes <input type="checkbox"/> No</b>		<b>If yes, please provide the following:</b>	
Provider Name:	Provider Phone: ( )	Date of Next Appt:	

**Please fax this form to your designated claim carrier:**

<b>Blue Cross Blue Shield of Arizona</b> administered by AmeriBen Transition of Care American Health Holding 9501 N.E. 2 <sup>nd</sup> Avenue Miami Shores, Florida 33138 Fax: (305) 756-1035	<b>UnitedHealthcare</b> Attn: Transition of Care 1311 W President George Bush Hwy Richardson, TX 75080 Fax# 800-628-0654	<b>Cigna Health Facilitation Care</b> Center Attention: Transition of Care 3200 Park Lane Drive Pittsburgh, PA 15275 Fax: (412) 747-7087	<b>Aetna</b> Transition of Care 7720 N 16 <sup>th</sup> Street, Suite 400 Phoenix, AZ 85020-4402 Fax: (860) 975-1430
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