UMR

A UnitedHealthcare Company

TRANSITION OF CARE REQUEST

This Plan provides transitional care benefits. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for conditions approved as transitional care, despite the fact that these expenses are no longer considered In-Network because the Plan changed approved networks.

To be eligible, you must have been, and continue to be, under a treatment plan by a Physician who was a member of a network previously used by this Plan. You must also complete this application no later than February 28, 2019 to be eligible for transition of care. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for six months for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to: Acute heart disease, Cancer, Acute trauma, such as bone fracture, Organ transplant candidates awaiting a donor, any immediate post-surgical follow-up included in the surgical fee paid for surgery received prior to the day of enrollment in this benefit, or Maternity in the second or third trimester.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

Patient Name: _____
Date of Birth: _____
Employee Name: _____ SS#: _____
Day Phone: _____ Home Phone: _____

Pregnancy: Name of OB/GYN: _____ Expected Delivery Date: _____
Hospital: _____
Provider contact info: _____

Surgery: Type and date of surgical procedure performed or scheduled within the next/last 60 days:
Procedure: _____ Date of Surgery: _____
Doctor: _____ Hospital/Facility: _____
Provider contact info: _____

Therapy: Post surgical? ___ Yes ___ No -- If post surgery, what type of procedure was performed?
(Please check one) ___Physical Therapy ___Occupational ___Cardiac Rehabilitation ___Speech
___Mental Health ____Other (Please explain: _____)
Therapy Provider: _____
Provider contact info: _____

Scheduled Radiology (X-Ray):
Type of Test 1: _____ Ordering Physician: _____
Type of Test 2: _____ Ordering Physician: _____
Scheduled CT Scan Date: _____ Facility: _____
Scheduled MRI Date: _____ Facility: _____
Treatment: ____ Chemo/Cancer ___ Rebetron/Hepatitis ____ Radiation/Cancer
Date of last treatment: _____
Provider contact Info: _____

Continued

Organ Transplant: Date of transplant:_____ Doctor:_____
Type of transplant:_____Medical Facility:_____
Provider contact info:_____

Other Services:
Standing Lab Orders: _____ Ordering Doctor:_____
Provider contact info:_____

Record Release: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any other medical information necessary to determine transition of services to my new coverage.

SIGNED_____**DATE** _____

Please fax this form in its entirety to:
fax # 877-266-6923

INTERNAL USE ONLY

Approval for: _____ TAX ID (if known): _____
Provider Name (Last, First)

_____
Address

☐ Verified Out of Network

Dates of Service: to Patient Diagnosis/ICD9: _____

CSR Name: _____ Date: _____

☐ Approval for all services

☐ Denied for all services

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