

Transition of Care & Continuity of Care Request Form

The following outlines Transition of Care and Continuity of Care and treatment of patients who are being treated by a provider that is not in-network under a given health plan.

What is Transition of Care?

Transition of Care provides new members the option to apply for extended coverage from their current, out-of-network healthcare provider at in-network benefits for a limited time period due to a specific medical condition until the safe transfer to a new in-network healthcare provider can be arranged.

What is Continuity of Care?

Continuity of Care is available if your provider leaves the network for your health plan and is now considered out-of-network. Continuity of Care provides members the option to apply for extended coverage from their current healthcare provider at in-network benefits for a limited time period due to a specific medical condition preventing an immediate safe transfer of care to a new in-network healthcare provider.

How do they both work?

You must already be undergoing active treatment by the identified out-of-network healthcare provider(s) for the condition(s) you are applying for under your Transition of Care/Continuity of Care request form(s).

- If your request is approved for the medical condition(s) included in your request form(s), you will receive the in-network level of coverage for treatment of the specific condition(s) by the out-of-network healthcare provider(s) identified within your form(s) for a defined period of time. All other services unrelated to the approved medical condition(s) and identified provider(s) must be cared for by an in-network healthcare provider in order for you to receive the in-network level of benefits.
- The availability of Transition of Care/Continuity of Care does not guarantee that a service or treatment is medically necessary or that it is covered under your health plan benefits. Depending on the type of service or treatment, a medical necessity review and determination and preauthorization of medical services may be required in order for a service or treatment to be covered under your health plan benefits.
- Active treatment is defined as a doctor visit or hospital stay with documented changes in a therapeutic regimen. This is within 30 days prior to your plan effective date or your healthcare provider's termination date.

What medical conditions are covered under Transition of Care & Continuity of Care?

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

- Pregnancy in the second or third trimester through six weeks postpartum at the time of the plan effective date or of the healthcare provider's termination date.
- High risk pregnancy. Pregnancy is considered 'high risk' if a mother's age is 35 years or older, or patient has/had:
 - Early delivery (three weeks) in previous pregnancy
 - Gestational diabetes
 - Pregnancy including hypertension
 - Multiple inpatient admissions during this pregnancy
- Newly diagnosed or relapsed cancer currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with the transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery).
- Acute conditions in active treatment such as heart attacks or strokes.
- Hospital confinement on the plan effective date.

What are some medical conditions that are not covered under Transition of Care & Continuity of Care?

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

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

How do I apply for Transition of Care & Continuity of Care?

To apply for Transition of Care / Continuity of Care, you will need to complete the request form (located on page 3-4) and mail or fax it along with relevant medical records and information to:

PfISD_Service@healthcarehighways.com

Fax: 214-975-2581

What is the deadline to apply for Transition of Care & Continuity of Care?

You must apply for Transition of Care / Continuity of Care no later than 31 days after the date your coverage begins or within 31 days of your healthcare provider's termination date.

If my request is approved, how long will I have to transition to a new in-network healthcare provider?

If it is determined that transitioning to an in-network healthcare provider is not recommended or safe for the medical conditions that qualify, services by the approved out-of-network healthcare provider will be authorized at the in-network level of benefits for a specified period of time (usually 90 days) or until care has been completed or transitioned to an in-network healthcare provider, whichever comes first. The specified period of time may vary and will be determined depending on the individual circumstances of the medical condition and/or treatment.

If my request is approved for one medical condition, can I receive in-network level of benefits for a non-related condition?

No. The in-network level of benefits provided as part of the Transition of Care / Continuity of Care is only for the approved, specific medical condition or illness and cannot be applied to another condition or illness. A separate Transition of Care / Continuity of Care request form must be completed for each medical condition or illness for which you or your dependents are seeking Transition of Care / Continuity of Care.

How will I know if I'm approved or denied for Transition of Care & Continuity of Care?

After receiving your request, a review will take place to evaluate the information provided and make a determination within 10 business days of receipt of your request. For new members, review will occur the earlier of, within 10 business days of the plan's effective date or receipt of your request. You will receive written notification to let you know if your request was approved or denied. A denial of your request will include information about how to appeal the determination.

Transition of Care & Continuity of Care Request Form

Applicant/Parent or Guardian:	
Please check one of the following, as applicable:	
☐ New member (Transition of Care applicant) ☐ Existing member whose healthcare provider terminated (Continuity of Care applicant)	
To complete this request form:	
- Please make sure all fields are complete. - Applicants complete both sections 1 and 2. - Healthcare providers currently treating condition complete section 3. - Use a separate request form for each condition. Attach additional information or medical support as needed. - When the application is complete, it must be signed by the member for whom the Transition of Care / Continuity of Care is being requested. If the patient is a minor, a legal guardian's signature is required. Signature provides authorization to release the applicant's medical records. - You must apply for Transition of Care / Continuity of Care within 31 days following the effective date of your coverage or of your healthcare provider's termination date. - Email or fax the completed request form along with any relevant medical support to: Email: PflSD_Service@healthcarehighways.com Fax: 214-975-2581 - After receiving your request, there will be a review and evaluation of the information provided and make a determination within 10 business days of receipt of your request. For new members, review will occur the later of, within 10 business days of the plan's effective date or receipt of your request. You will receive written notification to let you know if your request was approved or denied. A denial of your request will include information about how to appeal the determination. - Completion of this request form does not guarantee that a Transition of Care / Continuity of Care request will be granted.	
Section 1	To be completed by the applicant
Is the applicant pregnant in the second or third trimester of pregnancy? Due Date _____ (mm/dd/yyyy)	☐ Yes ☐ No
Is the applicant's pregnancy considered high risk? e.g., multiple births, gestational diabetes.	☐ Yes ☐ No
Is the applicant within six weeks postpartum at the time of the effective date?	☐ Yes ☐ No
Is the applicant currently undergoing a course of chemotherapy, radiation therapy, cancer therapy or terminal care?	☐ Yes ☐ No
Is the applicant undergoing treatment for symptomatic aids?	☐ Yes ☐ No
Is the applicant scheduled for a surgery or hospitalization after the effective date?	☐ Yes ☐ No
Is the applicant receiving treatment as a result of a recent major surgery?	☐ Yes ☐ No
Is the applicant receiving dialysis treatment?	☐ Yes ☐ No
Is the applicant receiving mental health or substance abuse treatment?	☐ Yes ☐ No
Is the applicant undergoing treatment for severe or end-stage kidney disease?	☐ Yes ☐ No
Has the applicant undergone a recent bone marrow or organ transplant, or is the applicant on the waiting list to obtain an organ?	☐ Yes ☐ No
If you did not answer "Yes" to any of the above questions, please describe the condition for which the applicant requests Transition of Care / Continuity of Care:	

Transition of Care & Continuity of Care Request Form



Section 2		To be completed by the applicant	
Applicant Name		Applicant Social Security Number or Member ID #	
Address	City	State/Zip Code	
Phone Number	Work Phone Number		
Employer Name		Applicant Date of Birth	
Medical Plan Effective Date (mm/dd/yyyy)			
Applicant Relationship to Employee (i.e., spouse, dependent, self)			
Are you currently covered by: ☐ Medicare ☐ Medicaid		Are you currently covered by other insurance? ☐ Yes ☐ No If yes, which carrier?	
Applicant's Authorization to release medical records: I hereby authorize the below healthcare professional to provide any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care / Continuity of Care.			
_____ Signature of Applicant / Parent or Legal Guardian		_____ Date	
Section 3		To be completed by healthcare provider currently treating condition	
Healthcare Professional Group Practice Name		Healthcare Professional Name	
Healthcare Professional Specialty	Healthcare Professional Phone Number	National provider Identifier (NPI) or Tax ID Number (TIN)	
Healthcare Professional Address	City	State/Zip Code	
Date of Last Visit	Next Scheduled Appointment (mm/dd/yyyy)	Frequency of Visits	
Reason / Diagnosis	Expected Length of Treatment		
Treatment Being Received	Date(s) of Admission (mm/dd/yyyy)		
Hospital	Hospital Phone Number		
Type of Surgery	Date(s) of Surgery (mm/dd/yyyy)		
If Maternity, Expected Date of Delivery	Is the treatment for an exacerbation or a previous injury or chronic condition?		
Current and Associated Treatment(s)/Healthcare Professional Comments. 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 the Member is applying for Transition of Care/Continuity of Care, you will need to complete a separate Transition of Care/Continuity of Care request form for each condition.			
_____ Signature of Healthcare Professional		_____ Date	