Transition of Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Transition of Care
The Transition Assistance Program provides a process that allows continued care for members when:

- They are a new enrollee to Anthem (except members with an Individual contract) and their treating provider is not part of the Anthem Blue Cross participating provider network.
- Continuity of care is at risk for reasons over which the member has no control. (Members who have **elected** to make changes in their coverage which cause them to be out-of-network are not eligible for this program).

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact Anthem Blue Cross Member Services.

Completing the Transition of Care Request Form
You may request Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. **An acute medical condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 90 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the Member Services number on the back of your Anthem Blue Cross card or the Member Services number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Mail the completed form to Anthem BCBS-Medical Management Department ATTN Medical Management Dept 108 Leigus Rd, Wallingford, CT 06492
- Or, fax this completed request form to 1-877-539-3851.

To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care.* ***For Medical Care****: If you are changing to a PPO or EPO and your current medical provider is in our network, or if you are changing to an HMO or POS and will stay in your current PMG or IPA, you do not need to complete this form. If you are in an HMO or POS and your provider is leaving the PMG/IPA, you do not need to complete this form, you need to contact your PMG/IPA and they will assist you with your transition to a contracting provider.* ***For Behavioral Health Care****: If you are changing plans and your provider is not in the Anthem network, please complete this form.*

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Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name:_____ Subscriber's Anthem ID #:_____

Subscriber's Employer:_____ Date Active with Anthem: _____

Patient's Name:_____ Relationship to Subscriber: _____ DOB:_____

Allergies: _____

Preferred Phone #:_____ ☐Home ☐Work ☐Cell Secondary Phone #:_____ ☐Home ☐Work ☐Cell

Name of Terminating Insurance Plan: _____

Circle Type of Terminating Plan: ☐HMO ☐POS ☐PPO ☐ EPO ☐CDHP ☐OTHER ☐ New

Anthem Plan: ☐HMO ☐POS ☐PPO ☐EPO ☐ ☐CDHP ☐OTHER

Are You a New Enrollee to Anthem Blue Cross: ☐Yes ☐No Name of Primary Care provider with the plan _____

For Network Disruption (PMG, IPA, PPO Provider, or Hospital has terminated from the Anthem Participating Provider Network) please provide the name of the terminating Hospital or Provider: _____

Diagnosis (include pertinent history and physical findings): _____

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1. Do you have an upcoming appointment to see a specialist? ☐Yes ☐No

If yes, please provide the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for pregnancy Due Date: Hospital for delivery:				
Other: Please be specific				

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2. Are you currently receiving any of the following services? ☐Yes ☐No

If yes, please provide the applicable information below.

Services	**Facility or Company, Medical or Behavioral Health Provider**
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐Yes ☐No

   Date_____Type of Surgery/Procedure _____

   Name/Phone Number of Physician performing surgery/procedure _____

   Hospital/Facility _____

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? ☐Yes ☐No

   Reason_____Hospital _____

   Date(s) of Service _____

5. Other Needs _____

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I hereby authorize the above provider to give the Anthem Blue Cross Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care. I understand that the Anthem Blue Cross Blue Shield Care Management may share information and discuss my care with my Primary Care Physician/Medical Group under my Anthem plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Anthem Blue Cross Blue Shield to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

Home Cell Work Do NOT leave confidential information on my voice mail.

Signature of Patient if 18 or over:	Date:
Signature of Parent or Guardian if Patient is under 18:	Date: