

Benefit Options

Choice. Value. Health.

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.

Employee Name:	DOB:	Employee ID#:
Dependent Name:	DOB:	EPO <input type="checkbox"/> RAN+AMN <input type="checkbox"/> United HealthCare
Day Time Phone: ()		PPO <input type="checkbox"/> AZ Foundation <input type="checkbox"/> Beech Street <input type="checkbox"/> United HealthCare
Address:		Medicare Primary <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:		Phone: ()
Do you use any specialty injectable medication other than insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list:		
Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.		
<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"/> Other: <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		
Do you have any health care concerns where you may need assistance from a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please explain:		
Are you currently receiving mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:
Provider Name:	Provider Phone: ()	Date of Next Appt:
Are you currently receiving substance abuse services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:
Provider Name:	Provider Phone: ()	Date of Next Appt:

Please fax this form to your designated claim carrier:

AFMC RAN+AMN Beech Street:
Strategic Health Development Corporation
Transition of Care
9501 N.E. 2nd Avenue
Miami Shores, Florida 33138
Fax: (305) 756-1035

UHC:
United Healthcare
Transition of Care
PO Box 30555
Salt Lake City, UT 84130-0555
Fax: (801) 567-5499

Confidentiality Notice: This document contains confidential information intended for a specific purpose and is protected by law.