Transition of Care Services Request Form

PRESBYTERIAN
Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Fax completed form to: (505) 843-3047

Date (MM/DD/YYYY): _____ **Employee/Subscriber's Name:** _____

Please use one form per family member

This form is to help you to transition you or your family's healthcare to Presbyterian Health Plan, Inc./ Presbyterian Insurance Company, Inc. **You may need to speak with your medical provider to complete sections of this form.**

Section 1: Transition of Care Information

- Transition of Care services are available for **90 days from your effective date** with Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc.
- Transition of Care services are available for **90 days following the termination date** of the provider's contract with Presbyterian Health Plan and Presbyterian Insurance Company.
- Prior Authorization is required for out-of-network services rendered by an out-of-network provider during the 90-day transition period. The Prior Authorization is subject to approval by a Presbyterian Health Plan medical director.
- For Point of Service and Preferred Provider Organization members: In some circumstances, out-of-network services approved for Transition of Care **may** be payable as in-network during the Transition of Care period.
- Transition of Care services are available for any of the reasons listed below.

Check (✓) all that apply if your treating provider is not an in-network provider

☐ I need a transplant, and I am scheduled for one, or just had one.

☐ I had a surgical procedure and undergoing follow-up care.

☐ I have a serious medical condition that requires ongoing care.

☐ I have a scheduled upcoming surgical procedure.

☐ I am in my second or third trimester of a pregnancy. Transition of Care is available for the remainder of the pregnancy, delivery, plus postpartum care.

☐ My network provider has terminated their contract with Presbyterian Health Plan and Presbyterian Insurance Company, and I checked one of the boxes above.

Section 2: Employer and Employee or Member Information

Employer Name (if insurance is through an employer):		
Employee/Member's ID Number/SSN:	Employee's Date of Birth: (MM/DD/YY)	
Employee/Member's Address (City, State, ZIP):	Employee/Member's Phone Numbers:	
	Work:	Home:
	Cell:	
This request is about: ☐ My Care ☐ Care of a family member (Dependent)		
If Transition of Care is for a Dependent, please complete the following:		
Dependent's ID Number/SSN:	Dependent's Date of Birth (MM/DD/YY):	
Home Phone:	Cellphone:	

Section 3: Medical Services Needs	
Diagnosis Codes (from your provider):	Description of Diagnosis:
Procedure/CPT Codes (from your provider):	
Description of services (include number of times services are needed and upcoming dates of service. For pregnancy services, please include delivery date):	**Date(s) of Service:**

Section 4: Provider(s) of Transitional Services Information	
Please complete the following information for the provider rendering the services.	
Name:	Phone Number:
Name:	Phone Number:
Name:	Phone Number:

Section 5: Case Management Request
Even if Transition of Care services are not needed, you may wish to use the services of a Presbyterian Health Plan nurse case manager. *If you have a chronic or serious medical condition, we may be able to help you access appropriate care.* Please list any chronic or serious health conditions:

For Presbyterian Use Only
Email sent to Enrollment, if special need identified ☐ **Done** ☐ **N/A**
Sent to Enrollment? ☐ **Yes** ☐ **No**

IMPORTANT CONFIDENTIALITY NOTICE

The document accompanying this message is intended for the use of the person or entity to whom this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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Presbyterian complies with civil rights laws and does not discriminate on the basis of protected status including but not limited to race, color, national origin, age, disability, or sexual orientation or gender expression. Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.

SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.

For more information, visit **https://www.phs.org/nondiscrimination**.