PRESBYTERIAN

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

Transition of Care Services Request Form

Fax completed form to: (505) 843-3047

Today's 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 health care 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 about **<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 (POS) and Preferred Provider Organization (PPO) 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 his/her 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:	Cell Phone:

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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.	
Provider Name:	Provider Number:
Provider Name:	Provider Number:
Provider Name:	Provider 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**

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