Transition of Care Form

General Information about Transition Assistance Program

Purpose of Transition of Care

Transition Assistance is a process that allows continued care for members when:

- Their primary medical group, PPO provider, hospital, or other provider is terminated from the participating provider network.
- They are a new enrollee in an Anthem plan (except members with an Individual contract) and their treating provider is not part of the participating provider network.
- Continuity of care is at risk for reasons over which the member has no control.

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 your Anthem Customer Service.

Completing the Transition of Care Form

You may request Transition of Care if:

- 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;
- Pregnant, regardless of trimester;
- You have a terminal illness;
- 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 180 days of the effective date of coverage for a newly covered enrollee.

Please mail or fax completed signed forms to the following:

Address: Anthem BlueCross BlueShield
Attn: UM Dept
Mail Stop GAG 006-0006
P.O. Box 4445
Atlanta, GA 30302

Fax: 1-877-663-2740 ATTN: UM Dept

- For questions: See ID card for Customer Service number

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 currently in a PPO and are changing to an Anthem PPO and your current medical provider is in our network, you do not need to complete this form. **For Behavioral Health Care**: If you are changing plans and your provider is not in the Anthem network, please complete this form.

Fill out the form completely, and do not leave any blanks. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscribers' Name _____

Subscriber's ID # _____

Employer _____

Date Active with Anthem _____

Patient's Name _____

Relationship to Subscriber _____

Home Phone# _____

Cell Phone # _____

Work Phone # _____ Ext: _____ Date of Birth _____

Hospital or Provider's name: _____

Circle the type of terminating plan: UHC Options PPO Network

Diagnosis (including pertinent history and physical findings) _____

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				

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Orthopedic Specialist				
Obstetrician for pregnancy				
Hospital for delivery:				
Due Date:				
Other: Please be specific				

2 Are you currently receiving any of the following services?

_____ Yes

_____ No

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

I herby authorize the above provider to give Anthem BlueCross BlueShield any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under Anthem BlueCross BlueShield. I understand I am entitled to a copy of this authorization form. I also authorize Anthem BlueCross BlueShield 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 over _____ Date _____