APPLICATION FOR TRANSITION OR CONTINUATION OF CARE

UnitedHealthcare
1311 W President Bush FWY
Richardson, TX 75080-113
Attn: Transition of Care
Fax 1-800-628-0654

BCBS of Illinois
PO Box 1220
Chicago, IL 60690
Attn: Full Service Unit – Transition Care
Fax 1-217-442-4809

Employee/Applicant:

Transition of Care is a service which enables Walgreens Health Plan *new* enrollees in either the BCBS or UnitedHealthcare plans on to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OF CARE BENEFITS?

- Read & *complete SECTION 1* of the application when applying for Transition of Care benefits.
- If you answer YES to at least one question, you may be eligible for Transition of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition of Care benefits. Should you require assistance locating a new physician in the UnitedHealthcare or BCBS network please visit us online at www.myuhc.com or www.bcbsil.com or call the customer care number shown on your medical ID card.

THE APPLICATION PROCESS

1. *Complete SECTION 2* if you answered YES to at least one of the questions in SECTION 1.
   - **Proceed to SECTION 2 only if you answered YES to at least 1 question in SECTION 1.**
   - Be sure to sign the authorization form to release your medical records.
2. Ask your physician to *complete SECTION 3* of the application.
   - **If you are receiving care from more than one physician, each one must individually complete SECTION 3.**
3. Mail or fax the completed application along with relevant medical records to the address or number noted on the top of this application prior to receiving care from an out of network provider or by **January 31th.** If you submit this application after January 31th you will not be eligible for the Transition of Care service. If you receive care from an out of network provider prior to approval by BCBS or UnitedHealthcare you may not be covered for those services. **(*Continuation of Care eligibility is based upon qualifying events listed in SECTION 1 and your Physician's information not your coverage effective date.)***

SECTION 1	**TO BE COMPLETED BY APPLICANT**	
Are you in your last 3 months of pregnancy or did you deliver less than 6 weeks ago?	☐ YES	☐ NO
Are you pregnant and has your doctor told you this is a moderate or high-risk pregnancy?	☐ YES	☐ NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	☐ YES	☐ NO
Are you undergoing treatment for symptomatic aids or terminal illness?	☐ YES	☐ NO
Are you undergoing treatment for severe or end-stage kidney disease?	☐ YES	☐ NO
Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	☐ YES	☐ NO
Are you undergoing ongoing therapy (i.e., PT, OT, speech, or cardiac)?	☐ YES	☐ NO

SECTION 2	**TO BE COMPLETED BY APPLICANT**	
Employee Name		Social Security Number
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name		Plan Effective Date
Patient Name		Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)		
Are you currently covered by: ☐ Medicare ☐ Medicaid	Are you currently covered by other insurance? ☐ YES ☐ NO If yes, which company?	

Authorization to release records:

I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition of Care Benefits under the plan.

_____ _____

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor — Date

(**OVER**)

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Physician:

Please fill out and check the entire form for completeness before submission to UnitedHealthcare or BCBS as appropriate

SECTION 3	**TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION**	
Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	Is treatment for an exacerbation of a previous injury or chronic condition? ☐ YES ☐ NO	
Current Treatment/Comments		
Signature of Physician		Date
SECTION 4	**FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE or BCBS**	
Care Coordination Representative's Name	Transition of Care: ☐ Approved ☐ Not Approved (please document reason below)	
Comments		
Care Coordination Representative's Signature		Date