TRANSITION OF CARE

Transition of Care is issued under special circumstances to allow members to continue treatment with non-network providers for a specific period of time to complete a course of treatment. Please complete the following Transition of Care form if you or one of your dependents is currently being treated by a provider who is **not** a participating provider in the PPO Blue Provider network. One form must be submitted for each non-participating provider.

Unstable or serious medical/mental conditions that require a limited course of treatment or follow-up care, such as those listed below may be eligible for Transition of Care benefits:

- Transplants
- Pregnancy
- Newly diagnosed cancer
- Short- and long-term psychotherapy and chemical dependency
- Recent heart attack
- Joint replacement
- Bone fractures
- Medical Injectable Drugs
- Other acute trauma or surgery

Examples of chronic medical conditions which typically are NOT eligible for Transition of Care include:

- Arthritis
- Diabetes
- Hypertension
- Asthma
- Allergies

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TRANSITION OF CARE FORM INSTRUCTIONS

TO PATIENT/EMPLOYEE: Please complete both sides of this form and return it to the following address **before** your effective date of coverage. Forms must be completed prior to your anticipated enrollment date. We are not responsible for forms mailed, faxed or delivered to any other location.

Highmark BCBS
Attn: PNC Dedicated Unit
Transition of Care Request
120 Fifth Avenue Place, Suite # 2028
Pittsburgh, PA 15222

Transition of Care (TOC) allows new enrollees to continue treatment that is in progress/ongoing with a non-participating provider (physician/facility/ancillary) or therapist for a period of time following the date of enrollment. Please complete this form if a non-participating provider is currently treating you or one of your dependents, and you are requesting to continue treatment with such provider for a specific period of time. If approved, this will entitle you to have covered services paid at the higher level under the HPN product. A separate form must be submitted for each non-participating provider.

- The request for Transition of Care must be for covered benefits that are medically necessary and appropriate.

- If the treating provider participates in the network for your program, do **NOT** complete this form. Please verify provider participation before completing this form.

- Approval is not guaranteed. You will receive confirmation of the decision once the review is complete. During this period, be sure to retain copies of any bills, receipts or Explanation of Benefits forms you may receive pertaining to the provider and treatment under consideration.

- If you have questions about Transition of Care or need help completing this form, please call the PNC Dedicated Unit at 1-800-241-5703.

- Covered services will still be subject to any plan deductible, coinsurance or co-payments and pre-certification and pre-authorization requirements and other limitations.

- All referrals for specialty care, diagnostic testing and related services must be made to participating providers and all other non-emergency in-patient care must be provided at participating hospitals and facilities.

TRANSITION OF CARE FORM INSTRUCTIONS

EMPLOYEE INFORMATION

Employee's Name: _____

Street Address: _____

City: _____ State: _____

Home Telephone #: (____) _____ Work Telephone #: (____) _____

Effective Date of Coverage: _____

Company Name: _____

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____

Relationship to Employee_____

Primary Care Physician's Name (if applicable) _____

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TRANSITION OF CARE INFORMATION

Condition being treated_____

What is the nature of the treatment?

_____

Was the patient hospitalized recently for this condition? ☐ Yes ☐ No

Admission Date: _____

If pregnancy related, at what hospital will you deliver? _____

Due Date_____

Physician/Facility/Ancillary Provider's/Therapist's name with whom you wish to continue care:

_____

Street Address: _____

City: _____ State Zip Code_____

Telephone Number (____) _____

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AUTHORIZATION TO RELEASE INFORMATION

I authorize _____

Non-Participating Physician, Specialist/Facility/Ancillary Provider/Therapist

_____

Address

To release to my Health Care Plan all information relating to past, present and future health care examinations, conditions and treatment for:

_____

Brief Description of medical or mental health condition

_____

I understand that Transition of Care (TOC) is subject to contractual limitations and exclusions set forth in the enrollment material. I also authorize my Health Care Plan to notify my PCP, if applicable, of the TOC approval with the non-participating provider.

Patient's Signature*: _____ Date: _____

Employee's /Legal Guardian's Signature: _____ Date: _____

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

To Health Care Plan: Use this space to include the address to which the physician/facility/ancillary provider/therapist should send medical records, if applicable.

_____

_____

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