ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

2018 TRANSITION OF CARE FORM

Please Note: This information pertains to you and/or your dependents health care and is not intended for authorization of services. *If you are currently under the care of a non-network provider, there are a limited number of medical conditions that may qualify for Transition of Care. If transitional care is appropriate, specific treatment by a non-network provider may be covered at the network level of benefits for a limited time period. These services are subject to eligibility and coverage limitations at the time the medical care is administered.* **This form must be submitted within 30 days of your new enrollment date.**

☐ **Please check box if this is dependent information.**

Employee Name:	**DOB:**	**State Employee EIN:**
Dependent Name:	**DOB:**	**EPO** ☐ Aetna ☐ BCBSAZ ☐ UHC ☐ Cigna **PPO** ☐ Aetna ☐ BCBSAZ ☐ UHC **HSA** ☐ Aetna
Day Time Phone:		
Address:		**Medicare Primary** ☐**Yes** ☐ **No**
Primary Care Physician:		**Phone:**

Do you use any specialty injectable medication other than insulin? ☐**Yes** ☐**No**
If yes, please list:

Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.

☐ Elective Surgery	Facility: *(Including transplant)* Date: Nature of Surgery:	Physician Name: Phone:
☐ Pregnancy	Due Date:	Physician Name: Phone:
☐ Radiation Oncology Date:	Facility:	Physician Name: Phone:
☐ Chemotherapy Date:	Facility:	Physician Name: Phone:
☐ Dialysis	Facility: Date:	Physician Name: Phone:
☐ Outpatient Rehabilitation	Facility: Date:	Physician Name: Phone:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Therapy

☐ Home Health Services Agency Name: Nature of Services:
(Including skilled nursing)

☐ Durable Medical Equipment Vendor Name:

Please check all that apply:
☐ Catheter supplies ☐ CPAP ☐ Bed/Mattress ☐ Other:
☐ Ostomy supplies ☐ Oxygen ☐ Wheelchair ☐ Diabetic Supplies

Do you have any of the following diseases: ☐ Diabetes ☐ Asthma ☐ CHF

Do you have any health care concerns where you may need assistance from a case manager? ☐ **Yes** ☐ **No**
Please explain:

Are you currently receiving mental health services: ☐ Yes ☐ No If yes, please provide the following:
Provider Name: Provider Phone: Date of Next Appt:

Are you currently receiving substance abuse services: ☐ Yes ☐ No If yes, please provide the following:
Provider Name: Provider Phone: Date of Next Appt:

Fax or Mail this Document to Your Medical Carrier Listed Below:

Aetna Public & Labor Segment Attn: Transition of Care 4645 E Cotton Ctr Blvd Bldg 1 Phoenix, AZ 85040 Fax: (860) 607-7288	**Blue Cross Blue Shield of Arizona** Attn: Transition of Care Mail Stop A223 PO BOX 13466 Phoenix AZ 85002-3466 Fax: (602) 864-3102	**Cigna Health Facilitation Care Center** Attn: Transition of Care 3200 Park Lane Dr Pittsburgh, PA 15275 Fax: (412) 747-7087	**UnitedHealthcare** Attn: Transition of Care 1311 W. Pres. George Bush Hwy Richardson, TX 75080 Fax: (800) 628-0654

Confidentiality Notice: This document contains confidential information intended for a specific purpose and is protected by law.