

TRANSITION OF CARE FORM

Please note that 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 period of time. These services are subject to eligibility and coverage limitations at the time the medical care is administered. **Confidentiality Notice: This document contains confidential information intended for a specific purpose and is protected by law.**

This form must be submitted within 30 days of your new enrollment date.

Please check box if this is dependent information.

Employee Name:	DOB:	Employee ID#:		
Dependent Name:	DOB:	EPO	PPO	HSA
Day Time Phone: ()		<input type="checkbox"/> Aetna	<input type="checkbox"/> Aetna	<input type="checkbox"/> Aetna
Address:		<input type="checkbox"/> BCBSAZ	<input type="checkbox"/> BCBSAZ	
		<input type="checkbox"/> UHC	<input type="checkbox"/> UHC	
		<input type="checkbox"/> Cigna		
		Medicare Primary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Primary Care Physician:	Phone: ()			
Do you use any specialty injectable medications other than insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please list:				
Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.				
<input type="checkbox"/> Elective Surgery <i>(Including transplant)</i>	Facility: Date: Nature of Surgery:	Physician Name: Phone:		
<input type="checkbox"/> Pregnancy	Due Date:	Physician Name: Phone:		
<input type="checkbox"/> Radiation Oncology Date:	Facility:	Physician Name: Phone:		
<input type="checkbox"/> Chemotherapy Date:	Facility:	Physician Name: Phone:		
<input type="checkbox"/> Dialysis Date:	Facility:	Physician Name: Phone:		
<input type="checkbox"/> Outpatient Rehabilitation Date:	Facility:	Physician Name: Phone:		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiac Therapy	
<input type="checkbox"/> Home Health Services <i>(Including skilled nursing)</i>	Agency Name:	Nature of Services:		
<input type="checkbox"/> Durable Medical Equipment	Vendor Name:			
Please check all that apply:				
<input type="checkbox"/> Catheter supplies	<input type="checkbox"/> CPAP	<input type="checkbox"/> Bed/Mattress	<input type="checkbox"/> Other:	
<input type="checkbox"/> Ostomy supplies	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Diabetic Supplies	
Do you have any of the following diseases: <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> CHF				
Do you have any health care concerns where you may need assistance from a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please explain:				
Are you currently receiving mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:		
Provider Name:	Provider Phone: ()	Date of Next Appt:		
Are you currently receiving substance abuse services: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the following:		
Provider Name:	Provider Phone: ()	Date of Next Appt:		

Please fax this form to your designated claim carrier:

Aetna Public & Labor Segment Transition of Care 4645 E Cotton Center Blvd, Bldg 1 Phoenix, AZ 85040 Fax: (860) 607-7288	Blue Cross Blue Shield of Arizona Attention Transition of Care Mail Stop A223 PO BOX 13466 Phoenix AZ 85002-3466 Fax: (602) 864-3102	Cigna Health Facilitation Care Center Attention: Transition of Care 3200 Park Lane Drive Pittsburgh, PA 15275 Fax: (412) 747-7087	UnitedHealthcare Attn: Transition of Care 1301 W. President George Bush Hwy Richardson, TX 75080 Fax: (855) 686-3561
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