ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

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** ☐ Aetna ☐ BCBSAZ ☐ UHC ☐ Cigna **PPO** ☐ Aetna ☐ BCBSAZ ☐ UHC **HDHP** ☐ Aetna
Day Time Phone: ( )		
Address:		**Medicare Primary** ☐**Yes** ☐ **No**
Primary Care Physician:		**Phone: ( )**

Do you use any specialty injectable medications 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 *(Including transplant)*	Facility: 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 Date:	Facility:	Physician Name: Phone:
☐ Outpatient Rehabilitation Date:	Facility:	Physician Name: Phone:

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

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

☐ 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:

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 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: (866) 729-0432	UnitedHealthcare Attn: Transition of Care 600 Airborne Parkway Cheektowaga, NY 114225 Fax: (855) 686-3561