

TRANSITION OF CARE FORM

**Must be submitted within 30 days
of your new enrollment date**

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.**

Please check box if this is dependent information.

Employee Name:		DOB:	Employee ID#:
Dependent Name:		DOB:	<input type="checkbox"/> BCBSAZ <input type="checkbox"/> UHC
Day Time Phone: ()		Medicare Primary: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:			
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> Nature of Surgery:	Facility: Date:	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:

Blue Cross Blue Shield of Arizona Attention: Transition of Care PO BOX 13466 Phoenix AZ 85002-3466 Fax: (602) 864-3102	UnitedHealthcare Attn: Transition of Care 600 Airborne Parkway Cheektowaga, NY 114225 Fax: (855) 686-3561
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