ARIZONA
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES

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:**	☐ BCBSAZ ☐ UHC
Day Time Phone: ( )		**Medicare Primary:** ☐**Yes** ☐ **No**
Address:		
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)* Nature of Surgery:	Facility: Date:	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 Please check all that apply: ☐ Catheter supplies ☐ CPAP ☐ Bed/Mattress ☐ Other: ☐ Ostomy supplies ☐ Oxygen ☐ Wheelchair ☐ Diabetic Supplies	Vendor Name:	
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:

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