TO PATIENT/EMPLOYEE: Please complete both sides of this form and return it to the following address **before** your effective date of coverage. Forms must be completed prior to your anticipated enrollment date. We are not responsible for forms mailed, faxed or delivered to any other location.

Highmark Blue Cross Blue Shield
Attention: Dave Homer
120 Fifth Avenue
Suite 1445
Pittsburgh PA 15222
Fax #- 412-544-7874

Transition of Care (TOC) allows new enrollees to continue treatment that is in progress/ongoing with a non-participating provider (physician/facility/ancillary) or therapist for a period of time following the date of enrollment. Please complete this form if a non-participating provider is currently treating you or one of your dependents, and you are requesting to continue treatment with such provider for sixty (60) days, unless otherwise defined by the employer group. This will entitle you to have covered services paid at the higher level under the PPO product. A separate form must be submitted for each non-participating provider.

• The request for Transition of Care must be for covered benefits that are medically necessary and appropriate.

• If the treating provider participates in the network for your program, do **NOT** complete this form. Please verify provider participation before completing this form.

• You will receive confirmation within two weeks. During this period, be sure to retain copies of any bills, receipts or Explanation of Benefits forms you may receive pertaining to the provider and treatment under consideration.

• If you have questions about Transition of Care or need help completing this form, please call the Customer Service at 800-811-0391.

• Covered services will still be subject to any plan deductible, coinsurance or co-payments and pre-certification and pre-authorization requirements and other limitations.

• All referrals for specialty care, diagnostic testing and related services must be made to participating providers and all other non-emergency in-patient care must be provided at participating hospitals and facilities.

EMPLOYEE INFORMATION

Employee's Name:
_____

Street Address: _____

City: _____ State: _____

Home Telephone #: ( ) _____ Work Telephone #: ( ) _____

Social Security #: _____ Effective Date of Coverage: _____

Company Name: _____

BOTH SIDES OF THIS FORM MUST BE COMPLETED TO PROCESS THIS REQUEST.

Patient Information

Patient's Name_____ Date of Birth_____

Relationship to Employee_____
Primary Care Physician's Name (if applicable)

TRANSITION OF CARE INFORMATION

Condition being teated_____

How long is treatment expected to continue? _____ years _____months

What is the nature of the treatment?
_____

Was the patient hospitalized recently for this condition? Yes No

Admission Date: _____

Did the patient have surgery? Yes No What type? _____

If pregnancy related, at what hospital will you deliver? _____Due Date_____

Physician/Facility/Ancillary Provider's/Therapist's name with whom you wish to continue care:
_____

Street Address:
_____

City: _____ State Zip Code_____

Telephone Number ( ) _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize

_____

Non-Participating Physician, Specialist/Facility/Ancillary Provider/Therapist

_____

_____

Address

To release to my Health Care Plan all information relating to past, present and future health care examinations, conditions and treatment for:

_____Brief Description of medical or mental health condition

_____

I understand that Transition of Care (TOC) is subject to contractual limitations and exclusions set forth in the enrollment material. I also authorize my Health Care Plan to notify my PCP, if applicable, of the TOC approval with the non-participating provider.

Patient's Signature*: _____ Date: _____

Employee's /Legal Guardian's Signature: _____ Date: _____

** If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

To Health Care Plan: Use this space to include the address to which the physician/facility/ancillary provider/therapist should send medical records, if applicable.