PRESBYTERIAN

Presbyterian Health Plan
Presbyterian Insurance Company, Inc.

Transition of Care Services Request Form

Fax completed form to: (505) 213-0246 or 1-888-923-9550

Today's Date (mm/dd/yr): _____ **Employee/Subscriber's Name**: _____

PLEASE USE ONE FORM PER FAMILY MEMBER

This form is to assist you in transitioning you or your family's health care to Presbyterian Health Plan/Presbyterian Insurance Company, Inc. (Presbyterian). **You may need to speak with your medical provider to complete sections of this form.**

SECTION 1: TRANSITION OF CARE INFORMATION

- Transition of Care services are available for about **30 days from your effective date** with Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian).
- Transition of Care services are available for **30 days following the termination date** of the provider's contract with Presbyterian.
- Benefit Certification is required for out-of-network services rendered by an out-of-network provider during the 30 day transition period. The Benefit Certification is subject to approval by our medical director.
- For Point-of-Service (POS) and Preferred Provider Organization (PPO) members, under some circumstances, out-of-network services approved for Transition of Care *may* be payable as in-network during the Transition of Care period.
- Transition of Care services are available for any of the reasons listed below.

Check (✓) all that apply if your treating provider is not an in-network provider

☐ I need a transplant, and I am scheduled for one, or just had one

☐ I had a surgical procedure and undergoing follow-up care

☐ I have a serious medical condition that requires ongoing care

☐ I have a scheduled upcoming surgical procedure

☐ I am in my 2nd or 3rd trimester of a pregnancy. Transition of Care is available for the remainder of the pregnancy, delivery, plus postpartum care.

☐ My network provider has terminated his/her contract with Presbyterian and I checked one of the boxes above

SECTION 2: EMPLOYER AND EMPLOYEE OR MEMBER INFORMATION

Employer Name (If insurance is through an employer):	
Employee/Member's ID Number/SSN:	Employee's Date of Birth: (mm/dd/yr)
Employee/Member's Address:	Employee/Member's Phone Numbers: Work: _____ Home: _____ Cell: _____
This request is about: ☐ My Care	☐ Care of a Family member (Dependent)
If Transition of Care is for a Dependent, please complete the following:	
Dependent's ID Number/SSN:	Dependent's Date of Birth (mm/dd/yr):
Home Phone:	Cell Phone:

SECTION 3: MEDICAL SERVICE NEEDS

Diagnosis Codes (from your provider):	Description of Diagnosis:
Procedure/CPT Codes (from your provider):	

Description of services (include number of times services are needed and upcoming dates-of-service. For pregnancy services, please include delivery date):	Date(s) of Service:

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SECTION 4: PROVIDER(S) OF TRANSITIONAL SERVICES INFORMATION	
Please complete the following information for the provider rendering the services.	
Provider Name:	Provider Number:
Provider Name:	Provider Number:
Provider Name:	Provider Number:

SECTION 5: CASE MANAGEMENT REQUEST
Even if Transition of Care services are not needed, you may wish to utilize the services of a Presbyterian nurse case manager. *If you have a chronic or serious medical condition, we may be able to assist you in accessing the appropriate care.* Please list any chronic or serious health conditions:

FOR PRESBYTERIAN USE ONLY		
E-mail sent to Enrollment, if special need identified	☐ **Done**	☐ **N/A**
Sent to Enrollment?	☐ **Yes**	☐ **No**