

**Presbyterian Health Plan
Transition of Care Referral Form**

General Information:

- Please call your new Primary Care Practitioner (PCP) or behavioral health provider/practitioner as soon as possible after enrollment to arrange for renewal of prescriptions, specialty referrals, or any other services.
- Either check the *Presbyterian Health Plan* Directory or call Presbyterian Health Plan Member Services to determine whether your healthcare providers are in the *Presbyterian Health Plan* network of providers.
- Arrange to have your records transferred from previous physicians as soon as you have chosen a new PCP.
- If you receive any Durable Medical Equipment (for example, supplies at home such as liquid oxygen), call the in-plan *Presbyterian Health Plan* Durable Medical Equipment provider listed in the Providers Directory.
- If you are receiving either home health care or physical, occupational, or speech therapy, please have the home care or therapy provider call *Presbyterian Health Plan* as soon as possible to obtain authorization. We will assist with the transition to in-plan providers, if necessary.
- Please indicate below any special circumstances for which we may be of assistance, including special care needs, scheduled deliveries for obstetrical care, concerns about continuity of care, or scheduled surgeries. Please feel free to indicate any concerns or questions that are not listed.

Today's Date: ___ / ___ / ___ Plan effective date: ___ / ___ / ___ Previous Insurer: _____

Current Employer: _____

Employee's Name: _____

Employee's information SSN: ___ - ___ - ___ D.O.B: ___ / ___ / ___

Employee's Address: _____

Telephone (work): _____ (home): _____ (cell): _____

This request is about: My Care Care of a Family Member: (name) _____

Information for member if other than employee SSN: ___ - ___ - ___ D.O.B: ___ / ___ / ___

Member's Address (if different than employee's): _____

Telephone (work): _____ (home): _____ (cell): _____

Description: (please include the medical condition, physician, and applicable dates)

Transition of care needed for an Out-of-Plan Provider

| Provider's First and Last Name and phone number | What you are seeing the provider for: | How many visits you need and the dates you will need to see the provider |
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