Continuity of Care/Transition Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care

The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Care Physician (PCP) or other provider is terminated from provider networks included in the member's plan
- They are a new member of Piedmont and their treating provider is not a participating provider within provider networks included in the member's plan
- Continuity of care is at risk for reasons over which the member has no control.

Completing the Continuity/Transition of Care Request Form

You may request Continuity/Transition of Care:

- If you are in an active treatment for an acute medical condition or a serious chronic condition.
  An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a newborn child between the ages of birth and 36 months.
  Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

<u>If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please complete this entire form and mail or fax to:</u>

Mail: Piedmont Community Health Plan
Attn: Medical Management
2316 Atherholt Rd.
Lynchburg VA 24501

Fax: 434-947-4465

Only complete this form if you are receiving ongoing care or are scheduled for care.
If you require standard preventative care or ongoing care for any chronic condition and you are not in an acute phase of your illness, requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs. Limited visits to an out of network provider may be approved for a limited time to allow you to choose an in-network provider for your care, as applicable. If you need assistance selecting a new provider you should contact Piedmont's customer Service at 434-947-4463.

Continuity of Care/Transition Care Request Form

PIEDMONT
COMMUNITY HEALTH PLAN

Patient Name:

Patient ID:

Please complete this entire form and mail or fax to:

Mail: Piedmont Community Health Plan
Attn: Medical Management
2316 Atherholt Rd.
Lynchburg VA 24501

Fax: 434-947-4465

You will be notified of the plan's decision in writing. All requests are evaluated on a case by case basis.
Complete a separate form for each member/patient making a request.
You must sign page 2 for the request to be processed.

Subscriber Name: ____ Subscriber ID: ___________________

Date of Birth: ________________

Patient Name: ____ Patient ID: ___________________

Date of Birth: ________________ Relationship to Subscriber: ____

Preferred Phone: ________________________________ Secondary Phone: ________________________________

Home Work Cell Home Work Cell

1. REASON FOR REQUEST (Check all that apply)

   The patient is new to Piedmont and the current care is being provided by an out of network provider.

   The patient's coverage with Piedmont has changed and care is being received from a provider who will be considered out of network with the new coverage terms.

   The patient's provider is no longer an in-network provider

   Other:____

2. DOES THE PATIENT HAVE AN UPCOMING APPOINTMENT TO SEE THE PROVIDER?

   No Yes (Please provide the applicable information below)

Specialist/Care Type	Provider Name (Last, First)	Provider Phone Number	Date of Visit	Reason for seeing provider

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Patient Name:

Patient ID:

3. DO YOU HAVE ANY HOSPITALIZATIONS, SURGERIES OR PROCEDURES SCHEDULED?

No Yes (Please provide the applicable information below)

Planned Date(s): ____

Type of Surgery/Procedure:____

Name of Physician Performing Surgery/Procedure: ____________________________________

Phone of Physician Performing Surgery/Procedure: ____________________________________

Hospital/Facility: ____

Please add additional information or explanation as needed below:

I hereby authorize Piedmont Community Health Plan Medical Management to obtain any information from applicable providers as necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I hereby authorize all above providers to provide Piedmont Community Health Plan Medical Management Department any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that Piedmont Community Health Plan Medical Management Department may share information and discuss my care with my new Primary Care Physician/Medical Group under my Piedmont plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Piedmont Community Health Plan to leave confidential information on my voice mail at the following number(s) listed above:

Home Work Cell Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over:	Date:
Signature of Parent or Guardian if Patient is under 18:	Date: