Continuity/Transition of Care Request Form

For Wellpoint plan members

Form completion tips

Complete and submit this form if you are currently receiving ongoing care or if you have services scheduled. Please do not complete and submit the form if you are not currently receiving ongoing care or if you do not have upcoming services scheduled.

You, your current physician, or a member of your physician's staff may complete and submit the form. Please mail, email or fax the completed form to Wellpoint as described at the bottom of the form.

Please complete and submit a *Continuity/Transition of Care Request Form* if any of the circumstances listed below apply:

- You are currently receiving or are scheduled to receive any of the following:
  - Prenatal/obstetrical care
  - Chemotherapy
  - Radiation therapy
  - Physical/occupational/speech therapy
  - Elective surgery
  - Ongoing treatment for an acute inpatient stay
  - Discharge planning after an acute inpatient stay, even if your previous health insurance carrier is still following your care
  - Dialysis
  - Home health care
  - Hospice care
  - Home IV therapy
  - Inpatient rehabilitation
  - Durable medical equipment
  - Supplies

Wellpoint

Continuity/Transition of Care Request Form

Instructions — Complete this form only if you are receiving ongoing care, or are scheduled to receive care, from a provider that is not a Wellpoint-contracted provider. Please complete a separate form for each covered family member who needs to have care transitioned to another provider.

Subscriber information

Last name	First name	M.I.	Date of birth

ID number (from Wellpoint ID card)	Group number (from Wellpoint ID card)	Date active with Wellpoint

Patient information

Last name	First name	M.I.	Date of birth

Preferred phone number ☐ Home ☐ Cell ☐ Work	Secondary phone number ☐ Home ☐ Cell ☐ Work

Current primary care physician/attending physician	New primary care physician/attending physician

Are you a new enrollee to Wellpoint? ☐ Yes ☐ No If Yes, please fill in rows a) and b). If No, skip to row c).

a) Name of terminating insurance plan	Type of terminating plan

b) Wellpoint plan name

c) Name of doctor or hospital canceling your care or terminating with Wellpoint

Diagnosis (include pertinent history and physical findings)

Medical information

1. **Do you have an appointment to see a specialist within the next six months? ☐ Yes ☐ No If yes, please provide the applicable information below.**

Type	Physician name (last, first) / Physician phone number	Physician address	Date of next office visit / Reason
Heart specialist	Name: Phone:		Date: Reason:
Lung specialist	Name: Phone:		Date: Reason:
Blood or cancer specialist	Name: Phone:		Date: Reason:
Neurologist	Name: Phone:		Date: Reason:
Infectious disease specialist	Name: Phone:		Date: Reason:
Kidney specialist	Name: Phone:		Date: Reason:
Surgeon	Name: Phone:		Date: Reason:

Medical information (continued)

Type	Physician name (last, first) / Physician phone number	Physician address	Date of next office visit / Reason
Obstetrician (pregnancy) Due date:_____	Name: Phone: Hospital for delivery:		Date: Reason:
Other (be specific): _____	Name: Phone:		Date: Reason:

2. Are you currently receiving any of the following services?

Oxygen	☐ Yes ☐ No	Company: _____
IV medication	☐ Yes ☐ No	Company: _____
Home therapy	☐ Yes ☐ No	Company: _____
Rehab treatment	☐ Yes ☐ No	Company: _____
Medical equipment	☐ Yes ☐ No	Company: _____
Dialysis	☐ Yes ☐ No	Company: _____
Laboratory	☐ Yes ☐ No	Company: _____
Physical therapy	☐ Yes ☐ No	Company: _____
Occupational therapy	☐ Yes ☐ No	Company: _____
Speech therapy	☐ Yes ☐ No	Company: _____
Radiation therapy	☐ Yes ☐ No	Company: _____
Other (be specific): _____	☐ Yes ☐ No	Company: _____

3. Do you have any hospitalizations, surgeries, or procedures scheduled? ☐ Yes ☐ No

Date:_____ Type of surgery / procedure:_____

Name / phone no. of physician performing surgery / procedure:_____

Hospital / facility: _____

4. Other needs / comments: _____

If you answered yes to any of the questions above, a nurse will contact you to coordinate your continuity of care, if appropriate.

Signature required

I authorize Wellpoint to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the Wellpoint reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the Wellpoint reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity/transition of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over X	Printed name	Date (MMDDYYY)
Signature of parent or guardian if patient is under 18 X	Printed name	Date (MMDDYYY)

Please mail this completed form to: Wellpoint
P.O. Box 4095
Woburn, MA 01888

You can also send us this form from your Wellpoint member account or fax it to 978-474-5162.