FirstCare
HEALTH PLANS
PART OF BAYLOR SCOTT & WHITE HEALTH

Continuity of Care/Transition of Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

What is Transition of Care? Transition of Care coverage allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with health care professionals who do not participate in the health plan's network until the safe transfer of care to a participating doctor or facility can be arranged**.** You must apply for Transition of Care at enrollment, or at the time of a health plan provider network change, but no later than 30 days after the effective date of your coverage.

What is Continuity of Care? Continuity of Care allows you to receive services at in-network coverage levels for specified medical and behavioral conditions for a defined period of time. Continuity of Care occurs when there are changes to your health plan network, and there are clinical reasons preventing immediate transfer of care to an in-network provider. A request must be submitted these services must be submitted to the health plan within 30 days of the network change.

How Transition of Care/Continuity of Care Works:

- You must already be under active treatment for the condition identified on the Transition of Care/ Continuity of Care request form.
- If Transition of Care/Continuity of Care is approved for medical or behavioral conditions, you will receive the in-network level of coverage for active treatment of the specific condition by the health care professional for a defined time frame, as determined by the health plan. If your plan includes out-of-network coverage and you choose to continue care out of network beyond the time frame approved by the health plan, you must follow your plan's out-of-network provisions. This includes any pre-certification requirements and any cost sharing and/or balance billing that may occur from the out-of-network provider.
- If approved, Transition of Care/Continuity of Care coverage applies only to the active treatment of the medical or behavioral condition specified and the health care professional identified on the request form. All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage levels.
- The availability of Transition of Care/ Continuity of Care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-certification may still be required for a service to be covered.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Routine Pregnancy in the second or third trimester at the time of the effective date of coverage or time of health care professional termination.
- High-risk pregnancy at the time of the effective date of coverage or time of health care professional termination. This is defined as:
  - early delivery (three weeks prior to due date) in previous pregnancy
  - patient has had/has gestational diabetes
  - pregnancy induced hypertension
  - multiple inpatient admissions during this pregnancy
  - mother's age is > 35 years old.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period (generally six to eight weeks).
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions, etc. For the purpose of this policy, "active treatment" is defined as a doctor visit or hospitalization with documented changes in a therapeutic regimen within 21 days prior to your plan effective date or your health care professional's termination date.
- Hospital confinement on the plan effective date.
- Behavioral health conditions during active treatment.

What time frame is allowed for transitioning to a new participating health care professional?
If the health plan determines that transitioning to a participating health care professional is not recommended or safe for the conditions that qualify, services by the approved non-participating health care professional will be authorized for a specified period of time or until care has been completed or transitioned to a participating health care professional, generally not to exceed 90 days unless otherwise authorized for an additional period of time.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, or one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. Customer advocates are available by phone, as always (http://firstcare.com/en/Contact-Us).

If one or more of the above situations applies to you and you would like to see if you are eligible to participate in transition of care, please:

- Call Customer Advocacy Number on the back of your ID card, and they will assist you with understanding how you should complete your form. Customer Advocacy will assist you in locating a network provider. The determination of whether you qualify for a transition or continuation of care will be made by the Health Services Department.
- Or, fax this completed request form to the Health Services Department at 1-800-248-1852.
- Or, mail to FirstCare Health Plans, 1901 W. Loop 289 Suite 9, Lubbock, Texas 79407 ATTN: Health Services Department

To help ensure that your care is not interrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care and your current provider is not part of our network. If your provider is not part of our network and you need assistance locating a network provider, contact Customer Advocacy and they will assist you with a network provider.

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❑ Transition of Care – New enrollee

❑ Continuity of Care – Existing member whose provider network has changed

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Employer	Policy #	Date of Enrollment in FirstCare (mm/dd/yyyy)	
Employee Name	Employee Social Security # or Alternate ID	Work Phone	Home Phone/Cell
Home Address Street City State ZIP			Email Address
Patient's Name	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee ❑Spouse ❑ Dependent ❑ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date_____(mm/dd/yyyy) ❑ Yes ❑ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ❑ Yes ❑ No
3. Is the patient currently receiving active treatment for an acute condition or trauma? ❑ Yes ❑ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with the Health Plan? ❑ Yes ❑ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
6. Is the patient receiving active treatment as a result of a recent major surgery? ❑ Yes ❑ No
7. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
8. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
9. Is the patient receiving mental health/substance abuse treatment? ❑ Yes ❑ No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

11. Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name		Health Care Professional Phone #
Health Care Professional Specialty		
Health Care Professional Address		
Hospital Where Health Care Professional Practices		Hospital Phone #
Hospital Address		
Reason Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

12. Is this patient expected to be in the hospital when coverage with the health plan begins or during the next 90 days? ❑ Yes ❑ No

13. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care Coverage. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care coverage, you need to complete a separate Transition of Care/Continuity of Care Form.

I hereby authorize the above provider to give the health plan any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care Benefits under the health plan. I understand that I am entitled to a copy of this authorization form. I also authorize the health plan to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply: ❑ Home ❑ Cell ❑ Work ❑ Email ❑ Do not leave confidential information on my voice mail	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-884-4901 (TTY: 711).

FirstCare Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-884-4901 (TTY: 711).

FirstCare Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-884-4901 (TTY: 711).

FirstCare Health Plans tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.