APPLICATION FOR TRANSITION OR CONTINUATION OF CARE

UnitedHealthcare
1311 W President Bush FWY
Richardson, TX 75080-1133
Attn: Transition of Care
Fax 1-800-628-0654

Employee/Applicant:
Transition of Care is a service which enables UnitedHealthcare *new* enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.
Continuation of Care is a service which enables UnitedHealthcare *existing* enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OR CONTINUATION OF CARE BENEFITS?

- Read & *complete SECTION 1* of the application when applying for ***either*** Transition or Continuation of Care.
- If you answer YES to at least one question, you may be eligible for Transition or Continuation of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition or Continuation of Care benefits. Should you require assistance locating a new physician in the UnitedHealthcare network, please visit us online at www.myuhc.com or call the customer care number shown on your medical ID card.

THE APPLICATION PROCESS

1. *Complete SECTION 2* if you answered YES to at least one of the questions in SECTION 1.
   - **Proceed to SECTION 2 only if you answered YES to at least 1 question in SECTION 1.**
   - Be sure to sign the authorization form to release your medical records.
2. Ask your physician to *complete SECTION 3* of the application.
   - **If you are receiving care from more than one physician, each one must individually complete SECTION 3.**
3. Mail or fax the completed application along with relevant medical records to the address or number noted on the top of this application **prior to 30 days *following the effective date*** of your UnitedHealthcare plan. If you submit this application after the 30th day of your coverage effective date, you will not be eligible for the Transition of Care service. ***Continuation of Care eligibility is based upon qualifying events listed in SECTION 1 and not your coverage effective date.***

SECTION 1	**TO BE COMPLETED BY APPLICANT**	
Are you in your last 3 months of pregnancy or did you deliver less than 6 weeks ago?	☐ YES	☐ NO
Are you pregnant and has your doctor told you this is a moderate or high-risk pregnancy?	☐ YES	☐ NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	☐ YES	☐ NO
Are you undergoing treatment for symptomatic aids?	☐ YES	☐ NO
Are you undergoing treatment for severe or end-stage kidney disease?	☐ YES	☐ NO
Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	☐ YES	☐ NO

For consideration of mental health and substance abuse services contact the mental health and substance abuse review organization at the telephone number included in your enrollment information or on your medical ID card.

SECTION 2	**TO BE COMPLETED BY APPLICANT**	
Employee Name		Social Security Number
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name		Plan Effective Date
Patient Name		Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)		
Are you currently covered by: ☐ Medicare ☐ Medicaid	Are you currently covered by other insurance? ☐ YES ☐ NO If yes, which company?	

Authorization to release records:
I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition or Continuation of Care Benefits under the plan.

_____ _____
Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor Date

(**OVER**)

APPLICATION FOR TRANSITION OR CONTINUATION OF CARE

Physician:

Please fill out and check the entire form for completeness before submission to UnitedHealthcare.

SECTION 3	**TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION**	
Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	Is treatment for an exacerbation of a previous injury or chronic condition? ☐ YES ☐ NO	
Current Treatment/Comments		
Signature of Physician	Date	
SECTION 4	**FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE**	
Care Coordination Representative's Name	Transition of Care: ☐ Approved ☐ Not Approved (please document reason below)	
Comments		
Care Coordination Representative's Signature	Date	