HealthCare Transition of Care Request Form

MERITAIN HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Customer service: 1.800.925.2272
Fax: 1.763.852.5078
Email: mnscan@meritain.com

This form represents a formal request to your health plan to cover continuing care from an out-of-network treating physician for a specified period of time. You will receive a coverage determination by mail. If this coverage request is not approved, care by the out-of-network provider after the Plan's effective date will be processed at the out-of-network level (based on your specific plan).

Please note this form is to be completed only if:

- You or a covered family member are using a doctor who does not participate in your primary preferred network of doctors or hospitals and you are currently undergoing a course of active treatment.
- You or a covered family member have an upcoming scheduled surgery or planned hospital admission at a facility not in your primary preferred network.

A list of medical conditions appropriate for consideration for transitional care are out lined in your Summary Plan Description (SPD). Please review the SPD for Transition of Care coverage details.

This Transition of Care Request form is not to be interpreted as a guarantee benefits. Benefits are subject to the plan provisions outlined in the Summary Plan Description and applicable to deductibles, coinsurance, plan maximums, etc. If approved, the letter of transition approval will be based on the assumption that the claimant will receive these services while covered under the plan, follow all other plan provisions as applicable and that the treatment plan will not change. Final benefit determination will be made upon receipt of the claim.

EMPLOYEE INSTRUCTIONS

1. Please complete sections 1, 2 and 3.
2. Read the authorization, sign and date this part of the form. If the patient is age 17 or older, he or she must also sign and date this form.
3. Give the form to the patient's out-of-network treating physician, who will complete section 4 and fax, mail or email the completed form to Meritain Health.

1. Employer Information	Employer's name (please print)	Plan effective date (required)	
2. Employee/Patient Information	Employee's name (please print)	Social Security number	
	Employee's address (please print)	Date of birth	Telephone number
	Patient name (please print)		
	Out-of-network treating physician's name/address (please print)	Telephone number	
3. Authorization	I am requesting coverage for continuing care by the provider named above for a condition for which treatment began prior to the plan effective date. If approved, I understand the continuing care specified below will be covered for a limited period. Further, I authorize the physician named below to provide medical information or records to the plan as required, to make a coverage determination.		
	Patient's signature (required if patient is 17 or older)	Date	
	Parent's signature (required if patient is 16 or younger)	Date	

4. Physician Information	Although you are not a participating provider in the plan network, the patient has requested that we cover care provided by you for a specified period of time because of a critical or serious/life threatening condition, or a pregnancy that began prior to the plan effective date. So we can evaluate your patient's request, please complete the information requested below. **For pregnancies, please enter patient's EDC.**	
	Out-of-network treating physician's name (please print)	Telephone number
	Out-of-network physician's group practice name (please print)	Provider tax ID
	Out-of-network physician's address (please print)	
	Hospital where out-of-network physician practices	Hospital telephone number
	Patient's diagnosis	**Expected length of treatment**
	Patient's current condition 1. Is the patient pregnant? ☐ Yes ☐ No If yes, when is the expected delivery date? (mm/dd/yyyy) _____ 2. Is the patient currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No 3. Is the patient scheduled for surgery or hospitalization? ☐ Yes ☐ No Expected date of surgery/admission: _____ 4. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care or a candidate for organ transplant? Specify ☐ Yes ☐ No 5. If treatment requested is related to an organ transplant, was the patient actively on the waiting list? if yes, please provide the date he or she was added to the waiting list. ☐ Yes ☐ No ☐ N/A Date:___/____/____ 6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No 7. Is the patient receiving mental health/substance abuse treatment? ☐ Yes ☐ No 8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests transition of care:	**Describe treatment plan and treatment dates** **If patient is receiving cancer treatment, please include treatment medications, dosages, frequency, etc.*
	Out-of-network physician's signature	**Date**