Stanford HEALTH CARE ALLIANCE

# Transition of Care Request Form

## Purpose of Transition of Care

The Transition of Care Program provides a process that allows members to receive assistance in transferring their specific care needs to the Stanford Health Care Alliance (SHCA) plan when they are a new enrollee in SHCA or their current SHCA provider is no longer contracted with the plan.

To avoid gaps in your treatment or charges from using non-participating doctors and/or ancillary services, please submit your Transition of Care Request Form as soon as you enroll or become aware of your transition of care needs. If you choose to continue care outside of the SHCA network without prior authorization for the service, the services will be considered not covered by the plan, and you will be responsible for the full cost of the service. Please call SHCA Member Care Services at **1-855-345-7422** with any questions.

**Note:** If you require ongoing care for any chronic condition and are not in an acute phase of your illness or requiring a special course of treatment, you should select an in-network provider to meet your ongoing healthcare needs. You do not need to complete this form. If you need assistance selecting a new provider, please call SHCA Member Care Services at **1-855-345-7422**.

## Completing the Transition of Care Request Form

We encourage you to fill out the Transition of Care Request Form or call if you think your health care needs require the assistance of our clinical team to assess your needs and determine when and to whom your treatment can be safely transitioned. Transition of Care requests occur either when a member is new to the plan or when a currently treating plan physician is no longer contracted with the plan. Members who have unique transition of health care needs requiring Transition of Care assistance may have the following types of health care conditions:

- Undergoing chemotherapy or radiation treatment for cancer
- Diagnosed with a terminal illness
- Waiting for a transplant or already working with a doctor towards a transplant
- Hospitalized at the time of the effective date of your new SHCA plan
- Receiving treatment for certain other acute or serious chronic conditions

**If one or more of the above situations applies, and you would like to verify eligibility for the Transition of Care Program, you must:**

- Call SHCA Member Care Services at **1-855-345-7422** or email the Transition of Care form to **cmreferrals@stanfordhealthcare.org** and request transition of care consideration as soon as possible.
- If you choose to continue care outside of the SHCA network without a prior approval for the services, these services will be considered not covered by the plan and you will be responsible for the full cost of the service.

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To ensure your care is not disrupted, please complete the form below as soon as possible. Complete a separate form for each family member who needs to have care transitioned to another provider.
*Note: If you are changing plans and your current provider is in the SHCA network, you do not need to complete this form.*

**Fill out the form completely. Use N/A if the information requested does not apply to your situation.**

Subscriber's Name: ____________________________________________________________

Subscriber's SHCA Number: ______________________________________________________

Subscriber's Employer: ______________________ Date Active with SHCA: ___________________

Patient's Name: ___________________________ Relationship to Subscriber: ________________

Date of Birth: _____________________________ Allergies: ______________________________

Preferred Phone #: __________________________ Home Work Cell

Secondary Phone #: _________________________ Home Work Cell

Name of Terminating Insurance Plan: _______________________________________________

Type of Terminating Plan: HMO PPO EPO OTHER

Are You a New Enrollee to SHCA? Yes No

Name of Medical Group with Terminating Plan: _________________________________________

Name of New SHCA Provider: ____________________________________________________

For Network Disruption (provider or hospital has terminated from the SHCA Participating Provider Network), please provide the name of the terminating hospital or provider:

_______________________________________________________________________________

Diagnosis (include pertinent history and physical findings): ____________________________

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**Do you have an upcoming appointment to see a specialist? Yes No**

If yes, please provide the applicable information below.

| **Specialist Type** | **Provider Name (Last, First)** | **Provider Phone #** | **Date of Office Visit** | **Reason** |
|---|---|---|---|---|
| Heart Specialist | | | | |
| Lung Specialist | | | | |
| Blood or Cancer Specialist | | | | |
| Neurologist | | | | |
| Infectious Disease Specialist | | | | |
| Kidney Specialist | | | | |
| Behavioral Health Specialist | | | | |
| Orthopedic Specialist | | | | |
| Obstetrician for Pregnancy Due Date: | | | | Hospital for delivery: |
| Other: Please be specific | | | | |

**2. Are you currently receiving any of the following services: Yes No**

If yes, please provide the applicable information below.

| **Services** | **Facility or Company; Medical or Behavioral Health Provider** |
|---|---|
| IV Medication/Chemotherapy | |
| Oxygen | |
| Clinical laboratory | |
| Physical/Rehab Therapy | |
| Radiation Therapy | |
| Home Therapy | |
| Organ or Stem Cell/Bone Marrow Transplant | |
| Medical Equipment | |
| Medication Management for a Behavioral Health Condition | |
| Dialysis | |
| Clinical Trial | |

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

Date: _______________________ Type of Surgery/Procedure: __________________________________

Name and phone # of physician performing surgery/procedure: _________________________________

Hospital/Facility: ______________________________________________________________________

**4. Have you been treated in the emergency room or admitted to the hospital in the past 6 months? Yes No**

If yes, please describe:

_____________________________________________________________________________________

_____________________________________________________________________________________

**5. Other Needs:**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

| I hereby authorize the above provider to give the SHCA Transition of Care Program any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care. I understand that I am entitled to a copy of this authorization form. I also authorize SHCA to leave confidential information on my voicemail at the phone number(s) listed below.<br>Please fill in all that apply:<br><br>Home #: ____________________ Cell #: ____________________ Work #: __________________<br><br>Do NOT leave confidential information on my voicemail ______ |
|---|
| Signature of patient if 18 or over: ________________________________________ Date: ________ |
| Signature of parent or guardian if patient is under 18: _______________________ Date: ________ |