

## REQUEST FOR TRANSITION OF CARE

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One of your concerns regarding enrollment in a CareFirst BlueCross BlueShield (CareFirst) plan may be that you or your covered dependent(s) are currently receiving care for an unstable or serious medical condition from a physician who is not a member of the provider networks.

### What is Transition of Care?

In order to ensure continuity of treatment, CareFirst offers a special program called "Transition of Care". If your request is approved, the Transition of Care program allows you or your covered dependent(s) to continue to receive care from a non-network physician for up to 90 days following the date of enrollment with benefits paid at the in-network level (i.e., minimal copayments and no calendar year deductible).

### Who should use this form?

If you or your covered dependent(s) have an unstable or serious medical condition that requires a limited course of treatment or follow-up care, and are currently being treated by a specialist who is not a participating provider with CareFirst's provider network, complete this form in order to be considered for the Transition of Care program. Information is required from both you and your physician.

Please be sure to submit a separate form for each non-participating physician currently treating you or your covered dependent(s) for the unstable or serious medical condition. Your newly selected participating CareFirst physician must coordinate all other unrelated treatment for you or your covered dependent(s).

*If the physician currently treating your condition participates in the CareFirst network, it is not necessary to complete this form. Instead, contact your new primary care physician to discuss the current treatment.*

Examples of medical conditions that may qualify for the Transition of Care program include:

- pregnancy (beyond 24 weeks gestation)
- bone fractures
- recent heart attack
- other acute trauma or surgery
- joint replacement
- newly diagnosed cancer

Examples of chronic medical conditions that typically are not eligible for the Transition of Care program include:

- arthritis
- asthma
- allergies
- diabetes
- hypertension
- COPD/emphysema

Please complete the Employee/Retiree Information and Patient Information sections on the other side of this form. Have the physician complete the Physician Information section. Return the form to the following address **BEFORE THE EFFECTIVE DATE OF YOUR COVERAGE**. No forms will be accepted after that date.

Qualified medical professionals in CareFirst's Care Management Department will review the request and notify the provider by phone of the determination within two (2) business days of receipt of all the required information. If the services are not approved, the provider and member will also be notified in writing.

### Mail the completed form and any attachments to:

CareFirst BlueCross BlueShield  
Preservice Review Department  
1501 South Clinton Street  
8th Floor  
Mail Stop: CT-08-02  
Baltimore, MD 21224

### Or fax the completed form and any attachments

to: 410-720-3060  
Attention: Pre-service Review

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

**- OVER PLEASE -**

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**THIS FORM CANNOT BE PROCESSED UNLESS COMPLETELY FILLED OUT**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone:( ) \_\_\_\_\_ Work Telephone:( ) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Effective Date of Coverage: \_\_\_/\_\_\_/\_\_\_  
Group Na \_\_\_\_\_ Group #: \_\_\_\_\_  
CIRCLE ONE: HMO                      POS                      PPO

Patient's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone:( ) \_\_\_\_\_ Work Telephone:( ) \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Relationship to Employee/Retiree: \_\_\_\_\_  
Name of New Physician (if known): \_\_\_\_\_  
New Physician's Code Number (located in the provider network directory): \_\_\_\_\_

Name of Physician Currently Treating Condition: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone:( ) \_\_\_\_\_ Specialty: \_\_\_\_\_  
Condition Being Treated: \_\_\_\_\_ Date treatment started: \_\_\_\_\_  
For Pregnancy, Please Indicate the Patient's Anticipated due date: \_\_\_\_\_

***Please attach the following:***

- a list of all treatment for the condition and dates rendered
- a brief statement of the patient's current condition and treatment plan
- names of other physicians who have treated the patient for this condition
- copies of any pertinent documentation (e.g., lab results, X-rays)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

This information is to be used for determining the appropriate level of benefit reimbursement for services that are provided on or after the effective date of my CareFirst coverage if I continue treatment with the above named provider for the above diagnosis/medical condition.

I understand that Transition of Care is granted at the discretion of CareFirst and is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Transition of Care does not extend the contractual benefits in any way except to provide the in-network level of benefits for a non-network provider for a temporary time period.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Employee/Retiree's Signature\*: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

\* If the patient is younger than 18, the employee/retiree must sign this form.