HealthCare Transition of Care Request Form

Complete Form and Mail to:
Central PA Teamsters H&W Fund
PO Box 15224
Reading, PA 19612
Fax: 610-320-9236
Email: hwfund@centralpateamsters.com

This form represents a formal request to your health plan to cover continuing care from an out-of-network treating provider 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, or after the end of the provider's contract with the primary preferred network, will be processed at the out-of-network benefit level (based on your specific plan).

Some things you should know about transition-of-care coverage
You'll find answers to commonly asked questions about transition-of-care coverage below. You should read them before filling out this form.

Transition-of-care coverage does not apply if your provider is in the plan's network (participating) or is part of your plan's highest benefit tier. The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

TRANSITION-OF-CARE COVERAGE QUESTIONS AND ANSWERS

Q. What is transition-of-care (TOC) coverage?
A. TOC coverage is temporary. You can get TOC when you become a new member of a medical benefits plan or change your plan and you are being treated by a doctor who:

- Is not in the plan's network

TOC coverage can also apply when your doctor leaves the plan's network or changes network status of if certain laws or regulations require coverage. Approved TOC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

TOC coverage is only for the requested doctor. Except in New York, TOC coverage may not include health care facilities, durable medical equipment (DME) vendors or pharmaceutical items. If we approve TOC coverage, the doctor must use a health care facility, DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for TOC coverage?
A. If you're receiving treatment, the procedure or service must be a covered benefit. Your doctor must also agree to accept the terms outlined on the TOC request form.

Q. How long does TOC coverage last?
A. Usually, TOC coverage lasts 90 days, but this may vary based on your condition (for example, pregnancy). We will tell you if your TOC coverage request is approved and how long the coverage will last.

Q. How do I sign up for TOC coverage?
A. Contact the Member Services number on your member ID card. You mut submit a TOC request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the plan's network
- Within 90 days of a doctor's network status change

You or your doctor can send in the request form.

Q. How will I know if my request for TOC coverage is approved?
A. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

Q. What if I have more questions about TOC coverage?
A. Call the Member Services phone number on your ID card. If you have questions about TOC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health number.

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.

This Transition of Care Request form is not to be interpreted as a guarantee of benefits. Benefits are subject to the plan provisions outlined in the APD and are applicable to deductibles, coinsurance, plan maximums, etc. Any 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, and 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 doctor or healthcare provider, who will complete section 4 and fax, mail or email the completed form to Central PA Teamsters H&W Fund.

1. Employer Information	Employer's name (please print)	Plan effective date (required)
2. Employee/Patient Information	Employee's name (please print)	Identification number (or Social Security number)
	Employee's address (please print)	Date of birth (mm/dd/yyyy)
	Patient name (please print)	Telephone number
3. Authorization	I request approval for coverage of ongoing care from the health care provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's network status change. If approved, I understand that the authorization coverage of services stated below will be valid for a certain period of time. I further understand that coverage will be subject to the benefits, exclusions, limits and maximums of my plan as of the date services are rendered. I give permission for the health care provider to send any needed medical information and/or records to the health plan so a decision can be made.	
	Patient's signature (required if patient is 17 or older)	Date (mm/dd/yyyy)
	Parent's signature (required if patient is 16 or younger)	Date (mm/dd/yyyy)

<table>
<tr><td rowspan="5">4. Provider Information</td><td colspan="2">The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan’s network. The patient has asked that we cover your care for a specific time period. If we approve this request, you agree:
• To provide the patient’s treatment and follow-up
• Not to seek more payment from this patient other than the patient responsibility under the patient’s plan of benefits (for example, patient’s copayment, deductibles or other out-of-pocket requirements) or as prescribed by law
• To share information on the patient’s treatment with us
You also agree to use the health plan’s network for any referrals, lab work or hospitalizations for services not part of the requested treatment.

So we can evaluate your patient’s request, please complete the information requested below. Please include a brief statement of the member’s current condition and treatment plan. For pregnancies, please enter the patient’s Estimated Date of Confinement (EDC).</td></tr>
<tr><td>Name of treating doctor or healthcare provider (please print)</td><td>Telephone number</td></tr>
<tr><td>Name of out-of-network physician’s group practice if different than above (please print)</td><td>Provider tax ID</td></tr>
<tr><td colspan="2">Address of treating doctor or healthcare provider (please print)</td></tr>
<tr><td>Hospital where treating doctor or healthcare provider practices</td><td>Hospital telephone number</td></tr>
<tr><td></td><td>Patient’s diagnosis</td><td>Expected length of treatment</td></tr>
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	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, serious illness, 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 use 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, upcoming surgery, treatment dates, etc.**

In the event this request is approved, you agree to provide the member's treatment and follow-up; to not seek payment from the member for any amount that the member would not be responsible for if you were a participating provider; to share information regarding the treatment plan with us; and, to use the plan's primary preferred network of provider for any necessary referrals, lab work or hospitalizations.

Signature of treating doctor or healthcare provider	**Date (mm/dd/yyyy)**