

# APPLICATION FOR TRANSITION OF CARE

UnitedHealthcare Transition of Care  
10701 West Research Drive, PO Box 26649  
Wauwatosa, WI 53226-3440

## 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.

### HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OF CARE BENEFITS

- Read & complete section 1 of the application.
- If you answer No to *every* question, you are NOT eligible for Transition of Care. Please contact the number on your ID card to have a service representative help you in finding a doctor in the UnitedHealthcare network.

### THE APPLICATION PROCESS

1. Complete part 2 if you answered YES to any of the questions in Section 1.
  - **Proceed to Part 2 only if you answered YES to at least 1 question in Part 1.**
2. Complete part 2 of the application.
  - **Be sure to sign the authorization form to release your medical records.**
3. Have your physician complete section 3 of the application.
  - **If you are receiving care from more than one physician, each one must individually complete section 3.**
4. Mail the completed application along with relevant medical records to the address 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 30<sup>th</sup> day of your coverage effective date, you will not be eligible for the Transition of Care service.

## APPLICATION FOR TRANSITION OF CARE

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?	<input type="checkbox"/> YES	<input type="checkbox"/>	NO
Are you pregnant and has your doctor told you this is a moderate or high-risk pregnancy?	<input type="checkbox"/> YES	<input type="checkbox"/>	NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	<input type="checkbox"/> YES	<input type="checkbox"/>	NO
Are you undergoing treatment for symptomatic aids?	<input type="checkbox"/> YES	<input type="checkbox"/>	NO
Are you undergoing treatment for severe or end-stage kidney disease?	<input type="checkbox"/> YES	<input type="checkbox"/>	NO
Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	<input type="checkbox"/> YES	<input type="checkbox"/>	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 member 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)			
<b>Are you currently covered by:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid		<b>Are you currently covered by other insurance?</b> <input type="checkbox"/> YES    If yes, which company?  <input type="checkbox"/> NO	
<b>Authorization to release records:</b>			
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 name above. This information will be used to determine the patient's eligibility for Transition of Care Benefits under the new plan.			
Patient's Signature/Parent Guardian's Signature			Date

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if Applicant is a Minor	
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**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	If treatment for an exacerbation of previous injury or chronic condition? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Current Treatment/Comments		
Signature of Physician		Date
SECTION 4		FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE
Care Coordinator Representative's Name	Transition of Care: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (please document reason below)	
Comments		
Care Coordinator Representative's Signature		Date