Continuity of Care/Transition of Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care

The Transition Assistance Program's purpose is to establish a consistent process for evaluating and responding to Transition of Care requests for new enrollees when:

- The Continuity of Care/Transition of Care Request Form is submitted to the Scott & White Health Plan (SWHP) or Insurance Company of Scott and White (ICSW) no later than 30 calendar days following the effective date of enrollment.
- The new enrollee is in active care for the acute and/or chronic condition
- The Member is a new enrollee in the SWHP or ICSW and their treating provider is not part of the Scott & White Health Plan/Insurance Company of Scott and White participating provider network.
- Members are receiving authorized care with non-Plan Practitioners/Providers providing services which were not previously available in Plan and for pediatric patients aged 18-26 who have chronic care needs and need to transition to adult care services.
- The provider is terminated from the Scott and White Health plan participating provider network while a current Member is in active treatment.
- Continuity of care is at risk for reasons over which the member has no control. (Members who have elected to make changes in their coverage which cause them to be out of network are not eligible for this program.
- Services eligible for Transition of Care are subject to benefit plan limitations and end when one of the following occurs:
    - Active care for the acute and/or chronic condition is completed;
    - Care is successfully transitioned to a participating health care professional;
    - Benefit limitations are exceeded;
    - Time period approved for Transition of Care coverage is exceeded;
    - New Enrollee Pediatric Members age 18-26 who have chronic care needs but have identified an in-network Provider for transitioning their adult services too.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact your Scott and White Health Plan Customer Advocacy Department.

Completing the Continuity/Transition of Care Request Form

You may request Continuity/Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. . Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, and in second or third trimester;
- If you have a terminal illness;
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 90 days of the effective date of coverage for a newly covered Member.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call Customer Advocacy Number on the back of your Scott and White Health Plan card and they will assist you with understanding how you should complete your form. Customer Advocacy will assist you in locating a network provider. The determination of whether you qualify for a transition or continuation will be made by the SHWP Health Services Department.
- Or, fax this completed request form to Customer Advocacy Fax # 254-298-3663
- Or, mail to Scott and White Health Plan, 1206 West Campus Drive, MS-A4-126, Temple, Texas 76508 ATTN: Customer Advocacy

To help ensure that your care is not disrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care. For **Medical Care**: If your current provider is already in our network there is no need to fill out this form. If your provider is not part of our network, do **not** complete this form (unless you are in ongoing active treatment or are already scheduled for care), you need to contact Customer Advocacy and they will assist you with a network provider.

Continuity of Care/Transition of Care Request Form

❑ Transition of Care – New Scott & White Health Plan enrollee
❑ Continuity of Care – Existing Scott & White Health Plan member

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Employer	Member #	Date of Enrollment in Scott and White Health Plan (mm/dd/yyyy)	
Employee Name	Employee Social Security # or Alternate ID	Work Phone	Home Phone/Mobile
Home Address Street City State ZIP			Email Address
Patient's Name	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee ❑ Spouse ❑ Dependent ❑ Self
Diagnosis / Reason	Name of Terminating Plan		

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date_____(mm/dd/yyyy) ❑ Yes ❑ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ❑ Yes ❑ No
3. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Scott and White Health Plan? ❑ Yes ❑ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
6. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ❑ No
7. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
8. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
9. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

_____

_____

_____

10. 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 Number	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				

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11. 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
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	
Other: Please be specific	

12. Do you have any hospitalizations, surgeries or procedures scheduled? ❑ Yes ❑ No

Type of surgery/procedure: _____ Date (mm/dd/yyyy): _____

Name of Physician performing surgery/procedure: _____

Hospital/facility: _____ Phone Number: _____

13. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? ❑ Yes ❑ No

Name of Hospital: _____ Date (mm/dd/yyyy): _____

Reason: _____

14. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care, you need to complete a separate Transition of Care/Continuity of Care form.

_____

I hereby authorize the above provider to give the Scott and White Health Plan 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 Scott and White Health Plan to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

❑ Home ❑ Cell ❑ Work ❑ Email ❑ Do Not leave confidential information on my voice mail

Signature of Patient, Parent or Guardian Date (mm/dd/yyyy)