Member Transition of Care Form

**PURPOSE**

It is the goal of the Payer Compass Medical Management Team to assist with transitioning from your previous medical benefit plan to your new plan. Please complete this form to help us make the transition as seamless as possible if you are receiving active treatment with for services such as:

* Chemotherapy/Radiation Therapy
* Intravenous Infusion
* Medical Supplies/Durable Medical Equipment
* Scheduled Surgeries/Procedures (approved by your previous medial benefit plan but not performed)

**INSTRUCTIONS**

* Please complete the TRANSITION OF CARE FORM providing as much information as possible. Please indicate any medications, medical supplies, procedures, or treatments you are concerned about transitioning immediately after your new medical benefit plans effective date.
* To allow us to ***obtain your medical records from your provider***, please complete, sign, and return the attached Authorization to Release PHI form.
* If you ***authorize your Protected Health Information (PHI) to be released to others***, please complete, sign, and return the attached Authorization to Release PHI form.
* Please return all forms to Payer Compass Medical Management by fax at 866-308-9225 or by email to utilizationreview@payercompass.com.
* Questions can be directed to Payer Compass Medical Management at 877-810-9939 during business hours of Monday through Friday 8:00 am to 6:00 pm EST.

# DEMOGRAPHICS

|  |  |
| --- | --- |
|  Name: |  |
| Date of Birth:  |  |
|  Address: |  |
| Preferred Phone Number:  |  |
| Alternative Phone Number:  |  |
| Email Address: |  |
| Emergency Contact Name:  |  |
| Emergency Contact Relationship: |  |
| Emergency Contact Phone Number: |  |

# MEDICAL SERVICES

|  |  |
| --- | --- |
| Active Medical Treatments *(Previously approved by your prior carrier)*: | 🞏Surgical Procedure I 🞏Chemotherapy I 🞏Radiation Therapy 🞏Infusions *(covered under medical benefit plan not pharmacy benefit plan*) 🞏Medical Supplies/DME I 🞏Home Health I 🞏Other (Provide description): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞏Case Management Program I Disease Management Program  |
| Diagnosis *(include all related to treatment)*:  |  |
| Surgical Procedure Name(s):  |  |
| Medication Name(s):  |  |
| Date of Next Scheduled Medical Service: |  |
|  Frequency of Medical Services: |  |
| Ordering Provider Name(s):  |  |
| Ordering Provider Phone Number: |  |
| Ordering Provider Address: |  |
| Facility Name Providing Medical Services:  |  |
| Facility Phone Number:  |  |
| Facility Address:  |  |

ADDITIONAL COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Disclaimer*** *– Standard Precertification and authorization procedures and guidelines apply. Transition of Care is a service for new members transitioning to your new medical plan with Medical Management performed by Payer Compass. Submitting this form does not guarantee continued care with providers, medical suppliers, or coverage. January 17, 2023*