TRANSITION OF CARE ASSISTANCE PROGRAM

Use the attached form to submit Transition of Care or Continuity of Care requests within 90 days of your transition needs.

Our Transition Assistance Program offers eligible members temporary, continued coverage, when undergoing active treatment from a doctor who is no longer part of your plan’s network. If coverage is approved, the program lets you complete your course of treatment or safely transfer to an in-network doctor or facility.

YOU MAY BE ELIGIBLE IF:

- You’re a new Blue Cross Blue Shield of Massachusetts member, and your plan’s treating provider is not part of your network
- Your continuity of care is at risk for reasons beyond your control, such as when your doctor leaves your plan’s network*

WHEN YOU SHOULD REQUEST TRANSITION OF CARE ASSISTANCE

You may submit a request for temporary continued coverage if you:

• Are in active course of treatment for an acute medical condition; a serious, chronic condition; cancer or chemotherapy; allergies; or a mental health condition.
• Are pregnant, regardless of trimester
• Have a terminal illness
• Have a surgery or other procedure that has been authorized under your previous plan and is scheduled to occur within 90 days of your new plan’s effective date
• Are enrolled in a cardiac rehab program that’s already in progress
• Have established care with a specialist treating your acute or serious chronic condition

If you need ongoing care for a chronic condition but aren’t in an active course of treatment, visit an in-network doctor for covered care that meets your needs.

How to Submit Your Request

Please complete the attached form, then submit it by fax or mail to Blue Cross using the address listed at the bottom of the form. Please allow two weeks for us to complete the review.

*Members who have elected to make changes in their coverage that cause them to be out-of-network are not eligible for this program.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.
Once we’ve received your medical records and completed our review, we’ll contact you and your doctor with the results. Please allow two weeks for us to complete this review.

**Choose Your Type of Request**

- **Transition of Care**
  - **Who Should Apply:** New Blue Cross members who are receiving ongoing treatment from a provider who is not part of the Blue Cross network
  - **If Approved:** You receive temporary, uninterrupted coverage for up to 90 days from your plan’s effective date

- **Continuity of Care**
  - **Who Should Apply:** Members who are receiving ongoing treatment from a provider who has recently left the Blue Cross network
  - **If Approved:** You receive temporary, uninterrupted coverage for a defined period of time

- **Continuity of Care** *(for members enrolled in a tiered plan)*
  - **Who Should Apply:** Members using a tiered provider network, who are receiving ongoing treatment from a provider who has moved to the highest cost-sharing tier
  - **If Approved:** You receive temporary, uninterrupted coverage at a lower-cost tier for a defined period of time

Please note: Continuity of Care request forms require the treating provider’s signature.

---

### Subscriber Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address – Number and Street</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Plan Effective Date</th>
<th>Blue Cross Member ID #</th>
</tr>
</thead>
</table>

---

### Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><em><strong>/</strong></em>/___</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (if different than subscriber)</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preferred Contact #</th>
<th>Home Phone #</th>
<th>Work Phone #</th>
<th>Cell Phone #</th>
</tr>
</thead>
</table>

**Do you have a primary care provider (PCP)?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please list your PCP’s name:

**Do you give us permission to contact your PCP with the results of this request?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

PCP Phone #: 
In the following fields, please list information for the patient and treating provider(s), and describe the care plan for the treatment(s) that you would like to be considered in this request. You may include information for more than one treatment in this request.

<table>
<thead>
<tr>
<th>Treatment Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment #1</strong></td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td>Specialty</td>
</tr>
<tr>
<td>Provider Address</td>
<td>City</td>
</tr>
<tr>
<td>Provider Phone #</td>
<td>NPI #</td>
</tr>
<tr>
<td>Date of Next Appointment</td>
<td>Length of Treatment</td>
</tr>
<tr>
<td>Provider Signature</td>
<td>Facility Name (if applicable)</td>
</tr>
<tr>
<td>Facility Address</td>
<td>City</td>
</tr>
<tr>
<td>Facility Phone #</td>
<td>NPI #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment #2 (Optional)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Specialty</td>
</tr>
<tr>
<td>Provider Address</td>
<td>City</td>
</tr>
<tr>
<td>Provider Phone #</td>
<td>NPI #</td>
</tr>
<tr>
<td>Date of Next Appointment</td>
<td>Length of Treatment</td>
</tr>
<tr>
<td>Provider Signature</td>
<td>Facility Name (if applicable)</td>
</tr>
<tr>
<td>Facility Address</td>
<td>City</td>
</tr>
<tr>
<td>Facility Phone #</td>
<td>NPI #</td>
</tr>
</tbody>
</table>
Treatment #3 (Optional)

Provider Name

Provider Address

City

State

ZIP Code

Provider Phone #

NPI #

Date Treatment Began

Date of Last Appointment

Date of Next Appointment

Length of Treatment

Expected Number of Visits

Treatment Plan Description

Provider Signature

Facility Name (if applicable)

Facility Address

City

State

ZIP Code

Facility Phone #

NPI #

Member Authorization

I hereby authorize the above provider to give the Blue Cross Blue Shield of Massachusetts Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care. I understand that Blue Cross Blue Shield of Massachusetts Care Management may share information and discuss my care with my Primary Care Physician/Medical Group under my plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Blue Cross Blue Shield of Massachusetts to leave confidential information on my voice mail at the number(s) listed above, unless I specify otherwise below.

Please check all that apply:

- [ ] Home
- [ ] Cell
- [ ] Work
- [ ] Do NOT leave confidential information on my voice mail.

Signature of Patient If 18 or Over

Date of Birth

_____ / _____ / _____

Signature of Parent or Guardian If Patient Is Under 18

Date

_____ / _____ / _____

Please complete this form in its entirety and mail or fax it to the address or appropriate number.

Mail to: Blue Cross and Blue Shield of Massachusetts

Attn: Health and Medical Management,

Clinical Intake Transition of Care

One Enterprise Drive, M/S 02/05

Quincy, MA 02171-2126

Fax to: 1-888-282-0780

(医疗和手术请求)

Fax to: 1-888-641-5199

(行为健康请求)

Questions?

If you have questions about completing this form, please call Member Service at the number on your ID card.