Transition of Care Form

(To be used when a member changes from another Health Plan to Anthem BCBS)

Our goal is to provide benefits for continuity of care for any new member of Anthem Blue Cross and Blue Shield who is receiving prenatal care or is in ***active*** *treatment for an acute or chronic condition with a* non-participating provider. Visits through the current period of active treatment **or** up to 90 days, depending on the care needs and circumstances will be approved. If the member chooses to continue her prenatal care with an out-of-network provider, the visits may be approved if the member is receiving prenatal care during the second or third trimester of pregnancy, and will continue through the provision of post-partum care directly related to the delivery.

If you or any covered family member are receiving care of this kind from a non-participating provider, please complete this form. Information provided will be kept confidential by Anthem Blue Cross and Blue Shield and will only be used in accordance with applicable privacy laws. Anthem Blue Cross and Blue Shield may share this information with your primary care provider (PCP) and/or specialist, and may be in contact with you to facilitate continuation of care.

Subscriber/Employer Info:

Subscriber Name: _____ Coverage Effective Date:_____
Group Number: _____
Employer Name: _____
Type of Coverage, i.e., (HMO, PPO) _____

Patient Info:

Patient Name: _____ Patient DOB: _____
Patient ID# _____ Home Telephone #: _____ Work Telephone# _____
Patient Address: _____
Best time to contact: _____

Provider Info Primary Care Provider (PCP): _____
PCP Address: _____
PCP Telephone #: _____

1) Specialist Name: _____ Telephone #: _____
Specialist Address: _____

2) Specialist Name: _____Telephone #_____
Specialist Address: _____

Services Requested for Transitional Care:

___ Ambulatory/Same Day Surgery ___ Durable Medical Equipment ___ GYN/infertility
___ Hospice Care ___ Inpatient Care (after surgery) ___ Mental Health
___ OB-Date of Delivery: _____ ___ Oncology ___ Out-of-Network Care
___ Outpatient Rehab (physical therapy, occupational therapy, speech therapy)
___ Pediatrics ___ Surgery/Treatment Type of Surgery_____
___ Transplant ___ Other: _____
___ Chronic/Long Term Illness, name of illness_____

Diagnosis:_____
Brief description of active treatment being received:

_____

_____

_____

Are you working with a nurse case manager with your Health Plan at this time? Yes / No (circle one)

If yes, what health care needs are being addressed?_____

Would you like to be contacted by the Case Management Department at Anthem to discuss your health care needs? Yes / No (circle one)

Signature of Subscriber/Guardian/Parent of the patient: _____

Date: _____

Please mail completed form to: **Attention Medical Management Department**
Anthem BCBS-Medical Management Dept.
2 Gannett Drive
So Portland ME 04106
(or) fax to: **Medical Management** at: **877-539-3856**

Note: For questions on filling out the form or if you need assistance on filling out the form please contact the number on the back of your ID card.