# Transition Assistance Request
# Continuation of Care Coverage Request

BlueCross BlueShield of Georgia

### What is Transition Assistance?

Transition Assistance is for newly enrolled members who wish to continue a relationship with an out-of-network provider they were using prior to enrolling. Blue Cross and Blue Shield of Georgia (BCBSGa) will offer assistance in locating an in-network provider.

### What is Continuation of Care?

Continuation of Care benefits enable you to continue to access physician services and facilities at in-network coverage levels for specified medical and behavioral conditions for a defined period of time and there are solid clinical reasons preventing immediate transfer of care to another in-network provider.

### General Information

You may be eligible to apply for an exception if you are in an active course of treatment for an acute medical condition or serious medical 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 medical condition** is a condition due to a disease, illness, mental health or substance abuse condition 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.

### Here are some examples of medical conditions that may qualify:

- Completing a course of treatment
- In an active course of treatment for cancer
- If pregnant
- Being treated for a terminal illness; Hospice Care
- Undergoing transplant care or waiting for a transplant
- Being treated for a serious medical condition

**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. Examples of conditions that do not qualify but are not limited to:

- Routine exams, vaccinations and health assessments
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma
- Elective (non-urgent) inpatient and/or outpatient surgery

### Instructions for completing the request form

- Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom an exception is being requested. If the patient is a minor, a guardian's signature is required.
- To help ensure a timely review of your request, please return the form as soon as possible.
- **Fax to: Medical Management (877) 254-4971.**

# ☐ Transition Assistance Request

# ☐ Continuation of Care Coverage Request

Instructions for completing the request form:

- Please make certain that all questions are completely answered. To help ensure a timely review of your request, please return the form as soon as possible.
- Section 1 and 2: completed by the patient for whom the care is being requested. If the patient is a minor, a guardian's signature is required.
- Section 3: completed by the treating care provider.
- **The treating care provider should fax the completed form to: Medical Management (877) 254-4971.**

## 1. PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient last name | Patient first name | | M.I. | Member ID no. |
| Street address | City | | State | Zip code |
| Home phone no. | Work phone no. | Sex | | Birthdate (MM/DD/YYYY) |
| Policyholder last name | Policyholder first name | | M.I. | Relationship to patient |
| Current insurance carrier (if other than BCBSGa) | Employer name | | | |
| Health plan: ☐ HMO ☐ PPO ☐ POS ☐ Other: _____ | | | | Effective date |

## 2. AUTHORIZATION

I am requesting coverage for Continuation of Care/Transition Assistance by the care provider named below for a condition for which treatment has started. I authorize the below care provider to give BCBSGa any and all information and medical records necessary to make an informed decision concerning my request for Continuation of Care benefits. **I hereby certify that the above information is true and correct to the best of my knowledge.**

| | |
|---|---|
| Policyholder signature<br>**X** | Date |
| Patient signature (If the patient is a minor, guardian's signature)<br>**X** | Date |

THE SECTION BELOW SHOULD BE FILLED OUT ONLY BY THE CARE PROVIDER/PHYSICIAN

Care provider – please provide the following:

- Pertinent diagnosis(es)
- Current and ongoing treatment plan with supporting medical documentation
- For hospitalizations or surgeries, provide a brief statement for inability to transfer care to in-network care provider
- If pregnancy, provide an estimated delivery date

## 3. CURRENT MEDICAL INFORMATION

| | | | |
|---|---|---|---|
| **Surgery**<br>☐ Inpatient<br>☐ Outpatient | Procedure | | Date scheduled |
| | Surgeon | | |
| | Hospital | | Hospital phone no. |
| **Maternity**<br>☐ Inpatient<br>☐ Outpatient | Expected delivery date | Obstetrician | |
| | Hospital | | Hospital phone no. |
| **Medical**<br>☐ Inpatient<br>☐ Outpatient | Diagnosis | | Date treatment began |
| | Treating physician | | |
| | Current treatment plan | | |

| | |
|---|---|
| Treating physician's name (please print) | Phone no. |
| Treating physician's address (please print) | Fax no. |
| Treating physician's signature<br>**X** | Date |