Transition of Care/ Continuity of Care Information

DEFINITIONS:

Transition of Care gives **new** members the option to request extended coverage from their current health care professional who will be out of network with the new plan. This is for a limited time due to a specific medical condition, and may continue until the safe transfer to a network health care professional can be arranged. The provider must agree to accept network rates. Examples of qualifying medical conditions can be found below. You must apply for transition of care no later than 30 days after the date your coverage begins using the enclosed application.

Continuity of Care gives **existing** members the option to request to extend care from their current health care professional if he or she is, or is soon to be out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time. Examples of covered medical conditions can be found below. You must apply for continuity of care using the enclosed application.

HOW TRANSITION OF CARE/CONTINUITY OF CARE WORKS:

You are eligible for a Transition of Care/Continuity of Care only when you have a significant medical condition that requires you to continue care with a specific provider as determined in each individual situation.

If your request is approved for the medical condition(s) listed in your application(s), you will receive the in-network level of coverage for treatment of the specific condition(s) by the health care professional for a defined time frame, as determined by us. All other services or supplies must be provided by a participating network health care professional for you to receive in-network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving care from the non-participating provider beyond the timeframe approved by us and agreed to by the provider, you must follow your plan's out-of-network requirements.

Depending on the actual request, a medical necessity determination and a notification or prior authorization may still be required in order for a service to be covered.

Examples of medical conditions that may qualify you for Transition of Care/Continuity of Care includes, but is not limited to:

- Pregnancy in the second or third trimester through six weeks post-delivery.
    - Transition of Care for the mother does not apply to the newborn. If the care provider or facility is out-of- network for the newborn, a Transition of Care request must be submitted for the newborn also.
- Ongoing treatment for a life threatening condition.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Ongoing treatment after a completed complex surgery or are in the middle of a staged surgery.
- Treatment for end-stage kidney disease and are on dialysis.
- Ongoing care after a recent organ transplant, or you are on the waiting list for a transplant with a specific physician.
- Ongoing treatment for acute significant psychiatric problems or other significant behavioral health services.
- Ongoing treatment for a rare and complex medical condition requiring continuity with a specific specialist.

Examples of conditions that do not qualify includes:

- Routine exams and pediatric care; care of chronic conditions like diabetes, arthritis, allergies, asthma, kidney disease and hypertension; elective surgeries and procedures.

Transition of Care/ Continuity of Care Information

WHAT DO I DO NEXT?

Fill out the enclosed application and submit by fax or mail with relevant medical records:

Fax to:
516.723.7392

Mail to:
Create TOC
P.O. Box 8030
Garden City, NY 11530

Transition of Care is a service which enables Create **new** enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Continuity of Care is a service which enables Create **existing** enrollees to receive time-limited care for specified medical conditions from a newly or soon to be non-contracted physician at the benefit level associated with contracted physicians.

TRANSITION OR CONTINUITY OF CARE BENEFITS APPLICATION FORM

Complete **SECTION 1 TO DETERMINE IF YOU ARE ELIGIBLE FOR TRANSITION OR CONTINUITY OF CARE BENEFITS**

- If you answer YES to at least one question, you may be eligible for Transition or Continuity of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition or Continuity of Care benefits.

To locate a new physician in your Benefit Plan network, please visit us online at:
mycreatehealth.com/network/providernetwork/Find

Complete **SECTION 2** if you answered YES to at least one of the questions in SECTION 1.

- **Proceed to SECTION 2 only if you answered YES to at least 1 question in SECTION 1.**
- Be sure to sign the authorization form to release your medical records.

SECTION 3 needs to be completed by your physician OR healthcare provider treating your condition.

- If you are receiving care from more than one provider, you must complete this form for **each** provider.

Finally, mail or fax the completed application along with relevant medical records to the address on the bottom of page 4.

- You must submit this form **no longer than 30 days** after your new Create plan coverage begins. If you submit this application after the 30th day of your new coverage effective date, you will not be eligible for the Transition of Care.
- **Eligibility also depends upon qualifying events listed in SECTION 1**

SECTION 1: TO BE COMPLETED BY APPLICANT

Select the type of care you are seeking coverage for: ☐ Transition of Care (**new** member) ☐ Continuity of Care (**existing** member)

Are you in your 2nd or 3rd trimester of pregnancy?	☐ Yes ☐ No
Are you undergoing treatment for a life threatening condition?	☐ Yes ☐ No
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	☐ Yes ☐ No
Are you undergoing treatment after a completed complex or staged surgery?	☐ Yes ☐ No
Are you undergoing treatment for end-stage kidney disease and are on dialysis?	☐ Yes ☐ No
Did you recently receive a transplant, or are you on the waiting list for a transplant with a specific physician?	☐ Yes ☐ No
Are you undergoing treatment for significant acute psychiatric or behavioral health services?	☐ Yes ☐ No
Are you undergoing treatment for a rare and complex medical condition requiring continuity with a specialist?	☐ Yes ☐ No

SECTION 2: TO BE COMPLETED BY APPLICANT

Employee Name		ID Number
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number

Preferred Number: ☐ Home ☐ Work ☐ Cell

Employer Name	New Plan Effective Date
Patient Name	Patient's Date of Birth

Patient's Relationship to Employee (i.e., spouse, dependent, self)

Are you currently covered by other insurance: ☐ Medicare ☐ Medicaid ☐ Other_____	TOC Provider Information: ☐ Physician ☐ Facility ☐ Other Name _____ Specialty (e.g. Heme-onc; Ob/Gyn, Hospital etc.) _____

Authorization to release records:
I authorize all health care professionals or institutions to provide information concerning medical care, advice, treatment, or supplies for the patient named above.

_____ _____

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor — Date

SECTION 3: TO BE COMPLETED BY HEALTHCARE PROVIDER OR FACILITY CURRENTLY TREATING CONDITION			
Physician / Provider Name		Provider NPI Number or TIN	Provider Contact Phone Number
Address		City	State/Zip Code
Date of Last Visit		Next Scheduled Appointment	Frequency of Visits
Diagnosis Code	CPT Code	Expected Length of Treatment, or if maternity, expected date of delivery?	
E-mail address:		Is treatment for an exacerbation of a previous injury or chronic condition?	

Please list Treatment Plan & Explanation why transition/continuation of care with the current provider/facility is medically necessary.

The above-named patient is a member of Create. We understand you are not, or soon will not be a participating provider in the network. This member has asked that for this episode of care, for a defined period of time, we treat claims from you for as in-network under the member's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. By this form, you agree to accept rules and fee schedules that apply to participating providers for this episode of care. Payment under this agreement, together with any copayment, deductible or coinsurance for which the member is responsible under the plan is payment in full for the covered service. You will not seek to recover additional payment from the member or us in excess of payment in full, regardless of whether such amount is less than your billed or customary charge. If applicable, you will make referrals for services including laboratory services, to network providers which can be found at mycreatehealth.com/network/providernetwork/Find.

Signature of Physician/Facility

Date

Please submit completed application and relevant medical records by fax or mail.

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Create TOC
P.O. Box 8030
Garden City, NY 11530

PRINT