Transition of Care Request Form

Meritain Health®
an aetna company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Customer service: 1.800.925.2272
Fax: 1.763.852.5078
Email: mnscan@meritain.com

This form represents a formal request to your health plan to cover continuing care from an out-of-network treating provider for a specified period of time. You will receive a coverage determination by mail. If this coverage request is not approved, care by the out-of-network provider after the Plan's effective date, or after the end of the provider's contract with the primary preferred network, will be processed at the out-of-network benefit level (based on your specific plan).

Please note this form is to be completed only if:

- You or a covered family member are using a doctor who does not participate in your primary preferred network of doctors or hospitals and you are currently undergoing a course of active treatment.
- You or a covered family member have an upcoming scheduled surgery or planned hospital admission at a facility not in your primary preferred network.

A list of medical conditions appropriate for consideration for transitional care are outlined in your Summary Plan Description (SPD). Please review the SPD for Transition of Care coverage details and deadlines for when this form must be received to have your request reviewed.

This Transition of Care Request form is not to be interpreted as a guarantee of benefits. Benefits are subject to the plan provisions outlined in the SPD and are applicable to deductibles, coinsurance, plan maximums, etc. If approved, the letter of transition approval will be based on the assumption that the claimant will receive these services while covered under the plan, follow all other plan provisions, as applicable, and that the treatment plan will not change. Final benefit determination will be made upon receipt of the claim.

EMPLOYEE INSTRUCTIONS

1. Please complete sections 1, 2 and 3.
2. Read the authorization, and sign and date this part of the form. If the patient is age 17 or older, he or she must also sign and date this form.
3. Give the form to the patient's out-of-network treating doctor or health care provider, who will complete section 4 and fax, mail or email the completed form to Meritain Health.

1. Employer Information	Employer's name (please print)	Plan effective date (required)
2. Employee/Patient Information	Employee's name (please print)	Identification number (or Social Security number)
	Employee's address (please print)	Date of birth (mm/dd/yyyy)
	Patient name (please print)	Telephone number
3. Authorization	I am requesting coverage for continuing care by the provider named below for a condition for which for which I am currently receiving care that was started before my plan effective date or before the end of the provider's contract with the primary preferred network. If approved, I understand the continuing care specified below will be covered for a limited period. I further understand that coverage will be subject to the benefits, exclusions, limits and maximums of my plan as of the date services are rendered. I authorize the physician named below to provide medical information or records to the plan as required, to make a coverage determination.	
	Patient's signature (required if patient is 17 or older)	Date (mm/dd/yyyy)
	Parent's signature (required if patient is 16 or younger)	Date (mm/dd/yyyy)

4. Provider Information	Although you are not or soon will not be a participating provider in the Plan network, the patient has requested that we cover care provided by you for a specified period of time because of a condition requiring an active course of treatment (for example a pregnancy). So we can evaluate your patient's request, please complete the information requested below. Please include a brief statement of the member's current condition and treatment plan. **For pregnancies, please enter the patient's Estimated Date of Confinement (EDC).**	
	Name of treating doctor or health care provider (please print)	Telephone number
	Name of out-of-network physician's group practice (please print)	Provider tax ID
	Address of treating doctor or health care provider (please print)	
	Hospital where treating doctor or health care provider practices	Hospital telephone number
	Patient's diagnosis	**Expected length of treatment**
	Patient's current condition 1. Is the patient pregnant? ☐ Yes ☐ No If yes, when is the expected delivery date? (mm/dd/yyyy) _____ 2. Is the patient currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No 3. Is the patient scheduled for surgery or hospitalization? ☐ Yes ☐ No Expected date of surgery/admission: _____ 4. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care or a candidate for organ transplant? Specify ☐ Yes ☐ No 5. If treatment requested is related to an organ transplant, was the patient actively on the waiting list? If yes, please provide the date he or she was added to the waiting list. ☐ Yes ☐ No ☐ N/A Date:__/___/___ 6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No 7. Is the patient receiving mental health/substance use treatment? ☐ Yes ☐ No 8. If you did not answer yes to any of the above questions, please describe the condition for which the patient requests transition of care:	**Describe treatment plan and treatment dates** **If patient is receiving cancer treatment, please include treatment medications, dosages, frequency, etc.*

In the event this request is approved, you agree to provide the member's treatment and follow-up; to not seek payment from the member for any amount that the member would not be responsible for if you were a participating provider; to share information regarding the treatment plan with us; and, to use the plan's primary preferred network of provider for any necessary referrals, lab work or hospitalizations. Since you no longer are a participating provider, your claim will be processed at the usual and customary rate applicable to the services rendered.

Signature of treating doctor or health care provider	**Date (mm/dd/yyyy)**