Transition and Continuity of Care 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

Transition of Care

New plan participants may be eligible for Transition of Care, a formal request to your health plan to cover continued services from an out-of-network treating provider for a specific period of time. If this coverage request is not approved, care rendered by the out-of-network provider after the plan's effective date will be processed at the out-of-network benefit level (based on your specific plan). **A list of medical conditions appropriate for consideration for Transition of Care are outlined in your Summary Plan Description (SPD). Please review your SPD for Transition of Care coverage details and deadlines for when this form must be received to have your request reviewed.**

Continuity of Care

Plan participants may be eligible for Continuity of Care when a treating provider is terminated from the primary preferred network. If this coverage request is not approved, care rendered by the out-of-network provider after the end of the provider's contract with the primary preferred network, will be processed at the out-of-network benefit level.

Please note:

The Transition of Care and Continuity of Care form is only completed 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 treatments.
- You or a covered family member have an upcoming scheduled surgery or planned hospital admission at a facility not in your primary preferred network.

You will receive coverage determinations for Transition of Care and Continuity of Care by mail.

Completion of this form is not to be interpreted as a guarantee of benefits. Benefits may be subject to the plan provisions outlined in the SPD and are applicable to deductible, coinsurance, plan maximums, etc. All approval letters assume 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(s).

Applicant to select one *(Required):*

☐ Due to contract termination, my treating provider no longer participates in the primary preferred network (CoC).
☐ I'm a new plan participant. My treating provider does not participate in the primary preferred network (ToC).

EMPLOYEE INSTRUCTIONS

1. Please complete section 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, they 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 complete 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 SSN)
	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 I am currently receiving care that began before my plan effective date or before my provider's contract was terminated with the primary preferred network. If approved, I understand the continuing care specified below will covered for a limited period. I further understand coverage will be subject to the benefit, 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 Signature (for patients 17 or older)	Date (mm/dd/yyyy)
	Parent signature (for patients 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 we cover care provided by you for a specific period of time due to a condition requiring an active course of treatment (for example, 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 pregnancy, please enter the patient's Estimated Date of Confinement (EDC).**	
	Name of treating doctor or care provider (print)	Telephone number
	Name of physician's group practice (print)	Provider tax ID
	Address of treating doctor or care provider (print)	Hospital/facility tax ID
	Hospital/facility where treating doctor or care provider practices (print)	Hospital/facility telephone number

<table>
<tr><td rowspan="2">5. Treatment Information</td><td>Patient's diagnosis</td><td>Expected length of treatment</td></tr>
<tr><td>Patient current condition

1. Is the patient pregnant ☐ Yes ☐ No If yes, list 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
If yes, what is the expected surgery/admission date (mm/dd/yyyy): _____

4. Is the patient receiving a course of chemotherapy, radiation therapy, cancer therapy, terminal care or a candidate of organ transplant?
☐ Yes ☐ No ☐ N/A
If yes, specify _____

5. If the treatment request is related to an organ transplant, is the patient on an active waitlist? ☐ Yes ☐ No
If yes, please specify the date the patient was added to the waiting list (mm/dd/yyyy): _____

6. Is the patient receiving treatment due to recent major surgery?
☐ Yes ☐ No

7. Is the patient receiving mental health/substance use treatment?
☐ Yes ☐ No

8. If you did not select "yes" to any of the above questions, please describe the condition for which the patient is requesting continued care:</td><td>Describe treatment plan and treatment dates. *If the patient is receiving cancer treatment, please specify treatment medications, dosages, frequency, etc.</td></tr>
<tr><td colspan="3">If this request is approved, you agree to provide the member's treatment and follow-up; not to seek payment from the member for any amount 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 providers for any necessary referrals, lab work or hospitalizations. Since you no longer are or will not be a participating provider at the time of service, your claim will be processed at the usual and customary rate applicable to the services rendered.</td></tr>
<tr><td colspan="2">Signature of treating doctor or health care provider</td><td>Date (mm/dd/yyyy)</td></tr>
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