Transition of Care Request Form

What is Transition of Care?

Transition of Care is issued under special circumstances to allow new members to continue treatment with non-network providers for a specific period of time to complete a course of treatment. You may currently be receiving services from health care providers or facilities that are outside of the Peak Health network. Completing a Transition of Care Request Form with subsequent approval would allow you to continue care for a medical condition, including pregnancy, under certain circumstances and for a specified period of time.

How it works?

Completed requests must be sent to Peak Health within 30 days of your enrollment. Forms may be completed and submitted by the member, member's authorized representative, and/or the member's current healthcare provider. If the member is completing the form, please share it with the healthcare provider. The provider should review the request and add all supporting clinical information before faxing to Peak Health for approval at 304-974-3191.

Who is eligible?

Members with unstable or serious medical/behavioral health conditions that require a limited course of treatment or follow-up care may be eligible for Transition of Care. Below are potential examples:

- Transplants
- Pregnancy
- Newly diagnosed cancer
- Short- and long-term psychotherapy and chemical dependency
- Recent heart attack
- Joint replacement
- Bone fractures
- Medical Injectable Drugs
- Other acute trauma or surgery

Member Name: _____ Date of Birth: ___ /___ /_____

Reason for requesting Transition of Care

I am requesting transition of care to continue treatment for the illness(es), condition(s), or health care service(s) listed below. Please be specific.

Protected Health Information Consent Form

I authorize _____

(Non-Participating Physician, Specialist/Facility/Ancillary Provider/Therapist)

_____

(Address)

To release to Peak Health all information relating to past, present and future health care examinations, conditions and treatment for:

_____

(Brief Description of medical or behavioral health condition)

_____

By signing below, I attest and understand that Transition of Care (TOC) is subject to contractual limitations and exclusions as set forth in my Evidence of Coverage, and I authorize Peak Health to notify my provider, if applicable, of the TOC approval with the non-participating provider.

Member's Signature*: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

*If member is younger than 18 years of age, the legal guardian must sign this form to authorize the release of medical information.

If you have any questions, please call Member Service at 1-833-5MY PEAK. Help is available Monday through Friday from 8 a.m. to 5 p.m.