



Promise Health
 PO Box 4278
 Clinton, IA 52733-4278
 Fax: 877-411-5964

Transition of Care Request Form
(Personal & Confidential)

This form represents a formal request for Promise Health to cover continuing care from a Non-Participating Treating Physician or coverage for non-covered, rental Durable Medical Equipment (DME) for a specified period of time. You will receive a coverage determination by mail. For PPO members, if the coverage requested is not approved, care by the non-participating provider after the plan's effective date either will not be covered or will be covered at the non-preferred rate, if such a rate is available under the member's benefit plan.

Employee Instructions

1. Please complete Sections 1, 2, and 3 . 2. Read the authorization, 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 Non-Participating Treating Physician, who will complete Section 4 and send the completed form to Promise Health			
1. Employer Information	Employer's Name (Please Print)	Group Number	Plan Effective Date <i>(Required)</i> <i>(MM/DD/YYYY)</i>
2. Employee - Patient Information	Employee Name (Please print)		Social Security/I.D. Number
	Employee's Address (Please print)		
	Patient's Name (Please print)	Birthdate <i>(MM/DD/YYYY)</i>	Telephone Number (include country &/or area code, as applicable)
	Name of Non-Participating Treating Physician or DME Provider (Please print)		Telephone Number (include country &/or area code, as applicable)
3. Authorization	I am requesting coverage for continuing care or DME by the provider named above for a condition for which treatment began prior to the Plan effective date or prior to termination of the provider. If approved, I understand that the coverage for continuing care or equipment rental specified below will be covered for a limited period. Further, I authorize the Physician or DME Provider named above to provide medical information or records to the Plan as required to make a coverage termination.		
	Patient's Signature (Required if Patient is 17 or older)		Date <i>(MM/DD/YYYY)</i>
	Patient's Signature (Required if Patient is 16 or younger)		Date <i>(MM/DD/YYYY)</i>
4. Physician Information	The above named patient is a member in a Promise Health Plan or will become a member in a Promise Health Plan as of the Plan effective date. 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, or a pregnancy that began prior to the Plan effective date or effective date of termination. An active course of treatment is defined as a planned program of service rendered by a physician or DME provider starting on the date a physician first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment. So that we can evaluate your patient's request, please list the patient's diagnosis below. List all treatment for the condition and the dates rendered, attaching additional sheets if necessary. Also attach a brief statement of the patient's current condition and treatment plan, together with appropriate medical records. For pregnancies, please enter the patient's EDC. In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.		
	Diagnosis	Diagnosis Code	Treatment
	CPT Code		
	Treatment Date(s) <i>(MM/DD/YYYY)</i>		
	Name of Non-Participating Treating Physician or DME Provider (Please print)		Telephone Number <i>(include country &/or area code, as applicable)</i>
	Address of Non-Participating Treating Physician or DME Provider (Please print)		
Signature of Non-Participating Treating Physician or DME Provider		Date <i>(MM/DD/YYYY)</i>	