

**STATE HEALTH BENEFIT PLAN
TRANSITION OF CARE APPLICATION**

Mail to: UnitedHealthcare
P.O. Box 30562
Salt Lake City, UT, 84130-0562

Employee/Applicant:

Transition of care is a service which enables State Health Benefit Plan new enrollees (PPO, Indemnity, High Deductible Health Plan and HMO) to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians. **Please note that you may be subject to balance billing by the non-contracted physician.**

HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OF CARE BENEFITS	
<ul style="list-style-type: none"> Read & <i>complete section 1</i> of the application. If you answer YES to at least one question, you may be eligible for Transition of Care benefits. If you answer NO to every question, you are NOT eligible for Transition of Care. Please contact the number on your ID card to have a service representative help you in finding a doctor in the UnitedHealthcare network. 	
THE APPLICATION PROCESS	
<ol style="list-style-type: none"> 1. <i>Complete section 2</i> if you answered YES to at least one of the questions in Section 1. <ul style="list-style-type: none"> Proceed to Part 2 only if you answered YES to at least 1 question in Part 1. Be sure to sign the authorization form to release your medical records. 2. Ask your physician to <i>complete section 3</i> of the application. <ul style="list-style-type: none"> If you are receiving care from more than one physician, each one must individually complete section 3. 3. Mail the completed application along with relevant medical records to the address noted on the top of this application no later than 30 days following the effective date of your UnitedHealthcare plan. If you submit this application after the 30th day of your coverage effective date, you will NOT be eligible for the Transition of Care service. 	
SECTION 1	TO BE COMPLETED BY APPLICANT
Are you in your 2nd or 3 rd trimester (14weeks or greater) of pregnancy at your effective date of coverage or did you deliver less than 6 weeks ago?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you pregnant and has your doctor told you this is a moderate or high-risk pregnancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer or in a hospice program for a terminal condition?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you undergoing treatment for severe or end-stage kidney disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you currently undergoing complex treatment for a serious long term illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
For consideration of mental health and substance abuse services contact the mental health and substance abuse review organization at 1-877-246-4189.	<input type="checkbox"/> YES <input type="checkbox"/> NO
SECTION 2	TO BE COMPLETED BY APPLICANT
Employee Name	Social Security Number
Address	City
Home Phone Number	Work Phone Number
Employer Name	Plan Effective Date
Patient Name	Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)	

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Are you currently covered by: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	Are you currently covered by other insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which company?
<p>Authorization to release records: I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition of Care Benefits under the new plan.</p>	
_____ Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor	
_____ Date	
(OVER)	

Physician:

Please fill out and check the entire form for completeness before submission to UnitedHealthcare.

SECTION 3 TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION		
Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	Is treatment for an exacerbation of a previous injury or chronic condition? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Current Treatment/Comments		
Signature of Physician		Date
SECTION 4 FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE		
Care Coordination Representative's Name	Transition of Care: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (please document reason below)	
Comments		
Care Coordination Representative's Signature		Date: