CareFirst
Family of health care plans

Information on Transition of Care Instructions

Welcome to CareFirst

One of your concerns as you seek enrollment in a CareFirst BlueCross BlueShield (CareFirst) and/or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) plan may be continuity of treatment. CareFirst and CareFirst BlueChoice members and their covered dependent(s) who receive care from an out-of-network physician for an unstable or serious medical condition may be eligible for the Transition of Care program.

What is Transition of Care?

In order to ensure continuity of treatment, CareFirst and CareFirst BlueChoice offer a special program called Transition of Care. If your request is approved, the Transition of Care program allows you or your covered dependent(s) to continue to receive care from an out-of-network physician for up to 90 days following the date of enrollment. Benefits will be paid at the in-network level (i.e., minimal copayments and no calendar year deductible.)

Who should use this form?

If you or your covered dependent(s) have an unstable or serious medical condition that requires a limited course of treatment or follow-up care, and are currently being treated by a specialist who is not a CareFirst and/or CareFirst BlueChoice participating provider, you should complete this form. Information is required from both you and your physician.

Please be sure to submit a separate form for each non-participating physician currently treating you or your covered dependent(s) for an unstable or serious medical condition. Your newly selected participating CareFirst and/or CareFirst BlueChoice physician must coordinate any other unrelated treatment for you or your covered dependent(s).

Note: If the physician treating your condition participates in the CareFirst and/or CareFirst BlueChoice network, it is not necessary to complete this form. Instead, contact your new primary care physician to discuss the current treatment.

Examples of medical conditions that may qualify for the Transition of Care program include:

- pregnancy (beyond 24 weeks gestation)
- bone fractures
- recent heart attack
- other acute trauma or surgery
- joint replacement
- newly diagnosed cancer

Examples of chronic medical condition that typically are not eligible for the Transition of Care program include:

- arthritis
- allergies
- hypertension
- asthma
- diabetes
- COPD/emphysema

Please complete the *Employee/Retiree Information* and *Patient Information* sections on the other side of this form. Also, have the physician complete the *Physician Information* section. Return the form to the following address **before the effective date of your coverage**. No forms will be accepted after that date.

Qualified medical professionals in the CareFirst and CareFirst BlueChoice Care Management Department will review the request and notify your provider of a determination by phone within (2) business days following the receipt of all required information. If the services are not approved, you and your provider will also be notified in writing.

Mail the completed form and any attachments to:
CareFirst BlueCross BlueShield
Pre-Service Review Department
1501 South Clinton Street
8th Floor
Mail Stop: CT-08-02
Baltimore, MD 21224

Or fax the completed form and any attachments to:
410-720-3060
Attention: Pre-Service Review

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.

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Request for Transition of Care Form

Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **www.carefirst.com**

INSURANCE INFORMATION

Member's Name		Date of Birth	
Street Address		Member ID	
City		Group Name	Effective Date of Coverage
State	Zip Code	Group Number	Check one HMO POS PPO
Home Telephone ( )			

PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

PHYSICIAN INFORMATION

Name of Physician Currently Treating Condition		Diagnosis Code(s) (ICD-10)	Date Treatment Started
Specialty		Procedure Code(s) (CPT/HCPCS)	Date of Next Treatment/Visit
Street Address		For Pregnancy, Please Indicate the Patient's Anticipated Due Date	
City		**Please attach the following:** List of services that may already be scheduled in the next few weeks (CPT code and date, provider) A brief statement of the patient's current condition and treatment plan Copies of any pertinent documentation (e.g., lab results, X-rays)	
State	Zip Code		
Telephone ( )			
Physician's Signature			Date

This information will be used for determining the appropriate level of benefit reimbursement for services provided on or after the effective date of my CareFirst coverage, if I continue treatment with the above named provider for the above diagnosis/ medical condition.

I understand that Transition of Care is granted at the discretion of CareFirst and is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Transition of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

Patient's Signature Date:

Employee/Retiree's Signature* Date

*If the patient is younger than 18, the employee/retiree must sign this form.

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