MASSACHUSETTS

TRANSITION OF CARE ASSISTANCE PROGRAM

Use the attached form to submit Transition of Care or Continuity of Care requests within 90 days of your transition needs.

Our Transition Assistance Program offers eligible members temporary, continued coverage, when undergoing active treatment from a doctor who is no longer part of your plan's network. If coverage is approved, the program lets you complete your course of treatment or safely transfer to an in-network doctor or facility.

YOU MAY BE ELIGIBLE IF:

You're a new Blue Cross Blue Shield of Massachusetts member, and your plan's treating provider is not part of your network

Your continuity of care is at risk for reasons beyond your control, such as when your doctor leaves your plan's network*

WHEN YOU SHOULD REQUEST TRANSITION OF CARE ASSISTANCE

You may submit a request for temporary continued coverage if you:

- Are in active course of treatment for an acute medical condition; a serious, chronic condition; cancer or chemotherapy; allergies; or a mental health condition.
- Are pregnant, regardless of trimester
- Have a terminal illness
- Have a surgery or other procedure that has been authorized under your previous plan and is scheduled to occur within 90 days of your new plan's effective date
- Are enrolled in a cardiac rehab program that's already in progress
- Have established care with a specialist treating your acute or serious chronic condition

If you need ongoing care for a chronic condition but aren't in an active course of treatment, visit an in-network doctor for covered care that meets your needs.

NEED TO FIND A DOCTOR?

Use our Find a Doctor & Estimate Costs tool to search for in-network providers at **bluecrossma.com/findadoctor**.

How to Submit Your Request

Please complete the attached form, then submit it by fax or mail to Blue Cross using the address listed at the bottom of the form. Please allow two weeks for us to complete the review.

*Members who have elected to make changes in their coverage that cause them to be out-of-network are not eligible for this program.

TRANSITION OF CARE ASSISTANCE REQUEST FORM

Once we've received your medical records and completed our review, we'll contact you and your doctor with the results. Please allow two weeks for us to complete this review.

Choose Your Type of Request

❑ **Transition of Care**

Who Should Apply: New Blue Cross members who are receiving ongoing treatment from a provider who is not part of the Blue Cross network

If Approved: You receive temporary, uninterrupted coverage for up to 90 days from your plan's effective date

❑ **Continuity of Care**

Who Should Apply: Members who are receiving ongoing treatment from a provider who has recently left the Blue Cross network

If Approved: You receive temporary, uninterrupted coverage for a defined period of time

❑ **Continuity of Care**
(for members enrolled in a tiered plan)

Who Should Apply: Members using a tiered provider network, who are receiving ongoing treatment from a provider who has moved to the highest cost-sharing tier

If Approved: You receive temporary, uninterrupted coverage at a lower-cost tier for a defined period of time

Please note: Continuity of Care request forms require the treating provider's signature.

Subscriber Information

Last Name	First Name	Middle Initial	Date of Birth _____/_____/_____
Address - Number and Street	City	State	ZIP Code
Plan Effective Date	Blue Cross Member ID #		

Patient Information

Last Name	First Name	Middle Initial	Date of Birth _____/_____/_____
Address (if different than subscriber)	City	State	ZIP Code

Preferred Contact # ❑ Home Phone # ❑ Work Phone # ❑ Cell Phone #

Do you have a primary care provider (PCP)? ❑ Yes ❑ No
If yes, please list your PCP's name:

Do you give us permission to contact your PCP with the results of this request? ❑ Yes ❑ No

PCP Phone #:

TREATMENT INFORMATION

In the following fields, please list information for the patient and treating provider(s), and describe the care plan for the treatment(s) that you would like to be considered in this request. You may include information for more than one treatment in this request.

Treatment #1				
Provider Name			Specialty	
Provider Address		City	State	ZIP Code
Provider Phone #	NPI #	Date Treatment Began _____/_____/_____	Date of Last Appointment _____/_____/_____	
Date of Next Appointment _____/_____/_____	Length of Treatment		Expected Number of Visits	
Treatment Plan Description				
Provider Signature				
Facility Name (if applicable)				
Facility Address		City	State	ZIP Code
Facility Phone #		NPI #		

Treatment #2 (Optional)				
Provider Name			Specialty	
Provider Address		City	State	ZIP Code
Provider Phone #	NPI #	Date Treatment Began _____/_____/_____	Date of Last Appointment _____/_____/_____	
Date of Next Appointment _____/_____/_____	Length of Treatment		Expected Number of Visits	
Treatment Plan Description				
Provider Signature				
Facility Name (if applicable)				
Facility Address		City	State	ZIP Code
Facility Phone #		NPI #		

Treatment #3 (Optional)

Provider Name		**Specialty**	
Provider Address	**City**	**State**	**ZIP Code**
Provider Phone #	**NPI #**	**Date Treatment Began** _____/_____/_____	**Date of Last Appointment** _____/_____/_____
Date of Next Appointment _____/_____/_____	**Length of Treatment**	**Expected Number of Visits**	
Treatment Plan Description			
Provider Signature			
Facility Name (if applicable)			
Facility Address	**City**	**State**	**ZIP Code**
Facility Phone #	**NPI #**		

Member Authorization

I hereby authorize the above provider to give the Blue Cross Blue Shield of Massachusetts Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care. I understand that Blue Cross Blue Shield of Massachusetts Care Management may share information and discuss my care with my Primary Care Physician/Medical Group under my plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Blue Cross Blue Shield of Massachusetts to leave confidential information on my voice mail at the number(s) listed above, unless I specify otherwise below.

Please check all that apply:

❑ Home ❑ Cell ❑ Work ❑ Do NOT leave confidential information on my voice mail.

Signature of Patient If 18 or Over	**Date of Birth** _____/_____/_____
Signature of Parent or Guardian If Patient Is Under 18	**Date** _____/_____/_____

Please complete this form in its entirety and mail or fax it to the address or appropriate number.

Mail to: Blue Cross and Blue Shield of Massachusetts
Attn: Health and Medical Management,
Clinical Intake Transition of Care
One Enterprise Drive, M/S 02/05
Quincy, MA 02171-2126

Fax to: 1-888-282-0780
(medical and surgical requests)

Fax to: 1-888-641-5199
(behavioral health requests)

Questions?

If you have questions about completing this form,
please call Member Service at the number on your ID card.