

Transition of Care Form

To complete this form

- Please make sure all fields are completed. Your health care professional should complete the care provider section.
- When the form is complete, it must be signed by the member for whom the Transition of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for Transition of Care within 60 days of the effective date of coverage.
- A separate Transition of Care form must be completed for each condition for which you and/or your dependents are seeking Transition of Care.

Submitting your form

Please send the completed form along with relevant medical records and information to:

**By mail: New York City Employees PPO (NYCE PPO) plan Transition of Care,
P.O. Box 8042, Wausau, WI 54402-8042**

By fax: 877-293-4926.

To submit online

1. Sign in to **nyceppo.com** or create your account.
2. Select **Message center** at the top of the screen.
3. Then choose **Email** and select **Compose a new message**.
4. In the **Subject line** drop-down, select **Medical – Benefits/Claims**.
5. Upload your signed Transition of Care form.
6. Select **Submit**.

Note: After receiving your request, NYCE PPO plan will review and evaluate the information provided. Incomplete forms will be returned to the requestor. Completion of this form does not guarantee that a Transition of Care request will be granted.

Patient information

Full name of person being treated _____ Date of birth / /
MM DD YYYY

Member ID number (refer to NYCE PPO ID card) _____

Address _____ City _____ State _____ ZIP _____

Phone number _____

Plan name **NYCE PPO** Group ID number **76-417151** Date of enrollment in the NYCE PPO plan / /
MM DD YYYY

Patient's relationship to employee Self Spouse Dependent Other _____

Authorization to release records:

I authorize all physicians and other health care professionals or facilities to provide information concerning medical care, advice, treatment or supplies for the patient named above. This information will be used to determine the member's eligibility for Transition of Care benefits under the plan.

Patient signature/parent or guardian's signature if member is a minor _____

Date / /
MM DD YYYY

Care provider section Your health care professional should complete the following information.

Name (treating physician or other health care professional) _____ National Provider Identifier (NPI) or Tax ID Number (TIN) _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Facility name _____ NPI or TIN _____ City _____ State _____

Facility phone _____ Date of last visit / / Next scheduled appointment / /
MM DD YYYY MM DD YYYY

Frequency of visits _____ Diagnosis _____ Expected length of treatment _____

If maternity, expected date of delivery / /
MM DD YYYY

Please select the service description(s) that applies:
Life-threatening condition Acute condition Transplant Inpatient/confined Upcoming surgery
Disabled/disability Terminal illness Mental health/substance use Ongoing treatment

Is the treatment for an exacerbation of a previous injury or chronic condition? Yes No

Current condition and associated treatment plan

(Include brief statement and all relevant CPT codes)

If these care needs are not associated with the condition for which you are requesting Transition of Care coverage, please complete a separate Transition of Care form for each condition.

We understand you are not a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking transitional coverage.

Please note the following: If the member is eligible, we will provide coverage. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any copayment, deductible or coinsurance for which the member is responsible under the plan, as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of health care professional _____ Date / /
MM DD YYYY

CONFIDENTIALITY NOTICE: Information in this document is considered to be confidential and/or proprietary business information. This information may be used only by the person or entity to which it is addressed. Any recipient shall be liable for using and protecting this proprietary business information from further disclosure or misuse, consistent with the recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime, and may also be subject to a civil penalty for each violation.