

Providence Transition of Care Request

We are happy that you have chosen us as your health plan. Please complete the steps below to submit your Transition of Care Request.

Transition of Care Description:

- A 90 day period may be considered on certain occasions
 - o New members
 - Member with change in plan or providers
- Begins on first day of new coverage

Consideration of Transition of Care Request:

- Reviewed case by case
- Decisions are based on medical necessity and not a guarantee of payment for services
- Payment is based on eligibility and benefits at time of service

When to Use Transition of Care:

- You are a new member to Providence
- You are a current member with a change to your insurance plan
- You need assistance to transition your providers under your new insurance plan

Checklist of Documents Needed to Review Your Transition of Care Request:

□Transition of Care Questionnaire Form (completed by member)

□ Consent for Release of Information Form (completed by member)

□ Prior Authorization Transition of Care Form (completed by provider)

□ Return the documents to:

- Mail 3601 SW Murray Blvd., Beaverton, OR 97005, Attn: Care Management
- Email <u>CareManagement@providence.org</u>
- Fax (503) 574-8171

Helpful Links and Phone Numbers:

- <u>https://healthplans.providence.org/</u> Providence Website
- <u>https://www.providence.org/provider-directory</u> Find a Provider
- <u>https://myprovidence.healthtrioconnect.com/</u> MyProvidence
- Providence Care Management: (503) 574-7247 or 800-662-1121 TTY: 800-735-2900
- Providence Customer Service: (503) 574-7500 or 800-562-8964 TTY: 800-735-2900
 Monday Thursday, 8am 6:30pm; Friday, 8am 5:30pm



Providence Transition of Care Questionnaire

Please complete the questionnaire for the individual with the care transition needs

Member Name:			Date of Birth:		
Phone Number:		Address:			
Member ID # (if known): Policy				der Name (if dependent)	:
 What type of coveration Medicaid Individual Plan Through Employ 		-		 Do you need assistance with any of the following? Behavioral Health Chemo/Radiation Substance Use Transplant Pregnancy Medical Equipment 	
 Are you a new or cu □ New 	Irrent member? □ Current		8.	Other: List provider. specialty	_
 If current, have you coverage? ☐ Yes 	had a benefit cl	d a benefit change to your		condition currently being treated, current medication(s), and the type of equipment and vendo for DME supplies:	
 Do you need assistanew providers? Yes 	nce establishing	g care with any			
 Are any of your curr with Providence? 					
☐ Yes If yes, list provider, 	□ No specialty and ph	Unknown oone number:	9.	Tell us more about you 	r situation:
 6. Do you have treatment scheduled prior to coming on plan? Yes No If yes, list the procedure, date, facility, provider and provider phone number: 				Questionnaire and	•
				Attn: Care M	

*** Chart Notes Required ** Processe all our PA department is You have any question at: 503-574-6400 or 800-638-0449 American Imaging Management (AIM) American Imaging Management (AIM) For High Tech Imaging American Imaging Management (AIM) Reduction of A department way question at: 503-574-6400 or 800-638-0449 American Imaging Management (AIM) Reduction of A department way question at: 503-574-6400 or 800-638-0449 American Imaging Management (AIM) Reduction of A department of A department way question at: 503-574-6400 or 800-638-0449 American Imaging Management (AIM) For High Tech Imaging American Imaging Management (AIM) Addressi Member Department is: Provident Phote at: 503-574-6400 or 800-638-0449 Last Name: Provident Phote at: 503-574-6400 or 800-638-0449 Address: Provident Information Provider: Provider: TIN#: Address: NPI#: Servicing Provider: TIN#: Address: NPI#: CPT Code(s): Request Information CPT Code(s): Inpatient Optional Surgery Office Surgery Opfice Surgery Opfice Surgery Diagnostic Inpatient Opfice Surgery </th <th>+ PROVIDENCE Prior Author</th> <th>rization Request TROVIDENCE Medicare Advantage Plans</th>	+ PROVIDENCE Prior Author	rization Request TROVIDENCE Medicare Advantage Plans					
Please fax this request to: 503-574-6464 or 800-989-7479 Proteste call our PA department if you have any questions at: 503-574-6400 or 800-638-0449 For High Tech Imaging American Imaging Management (AIM) Radiology Prior Authorization Phone: 800-920-1250 For Online Request: http://www.americanimesing.met/goweb/ For Registration: Providence PIN #: 045-83169 Last Name: Member Information Last Name: Provider: Tim#: ODB: Address: TIN#: Address: NPI#: Servicing Provider: NPI#: Servicing Provider: NPI#: NPI#: Address: NPI#: Servicing Facility: NPI#: Address: Outpatient Surgery Outpatient Surgery Outpatient Surgery Diagnostic Type of Service: Inpatient Outpatient Surgery Diagnostic Jasc Dote Surgery Outpatient Surgery Outpatient Surgery Disgnostic Service:	**Chart No	otes Required**					
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IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message. November 14, 2018



AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION RELEASE BY A THIRD PARTY TO PROVIDENCE HEALTH PLAN THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID

authorize:

(*Name of provider/person/entity disclosing information*) (Address) to disclose a copy of the specific health information described below regarding:

Name of Individual:

Date of Birth:

to **Providence Health Plan (PHP)** for the purpose of coordinating the transition of mycare to Providence Health Plan. The specific health information to be used/disclosed consists of (*Describe condition(s), treatment(s), dates of service, etc.*))

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

 HIV/AIDS test	or result	inform ation	and related	l records	 Mental	health information	
 Drug/alcohol	diagnosis,	, treatment,	or referral	information	 Genetic	testing information	۱

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in Providence Health Plan or my eligibility for benefits.

I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization. Any uses or disclosures already made with my Authorization cannot be taken back.

To revoke this Authorization, please send a written statement to Providence Health Plan at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.

I understand that the information used or disclosed pursuant to this Authorization maybe subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS testor result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will shall be in force and effect until the following (check one):

- OR - Event:

at which time this Authorization to use or disclose this protected health information expires. Further, this Authorization expires 24 months from the date of signature. I have reviewed and I understand this Authorization.

By:_____ (Individual)

- OR -

By:			Date:
(Individual's representative)			
Relationship to membe	er: Parent	Legal guardian*	Holder of Power of
Attorney*			
	*Diagon otto ob logol	doour ontotion if you are the local	guardian or Haldar of Dowar of

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Date: