PROVIDENCE Health Plan

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
  - 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 – CareManagement@providence.org
- Fax – (503) 574-8171

Helpful Links and Phone Numbers:

- https://healthplans.providence.org/ – Providence Website
- https://www.providence.org/provider-directory – Find a Provider
- https://myprovidence.healthtrioconnect.com/ – 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 Health Plan

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 Holder Name (if dependent): _____

1. What type of coverage do you have?
   ☐Medicaid ☐Medicare
   ☐ Individual Plan
   ☐ Through Employer (specify employer):
   _____

2. Are you a new or current member?
   ☐ New ☐ Current

3. If current, have you had a benefit change to your coverage?
   ☐ Yes ☐ No ☐ Unknown

4. Do you need assistance establishing care with any new providers?
   ☐ Yes ☐ No ☐ Unknown

5. Are any of your current providers <u>not</u> contracted with Providence?
   ☐ Yes ☐ No ☐ Unknown
   If yes, list provider, specialty and phone number:
   _____
   _____
   _____

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: _____
   _____
   _____
   _____
   _____

7. Do you need assistance with any of the following?
   ☐ Behavioral Health ☐ Chemo/Radiation
   ☐ Substance Use ☐ Transplant
   ☐ Pregnancy ☐ Medical Equipment
   ☐ Other: _____ ☐ Medication
   _____

8. List provider, specialty and phone number for each condition currently being treated, current medication(s), and the type of equipment and vendor for DME supplies:
   _____
   _____
   _____
   _____
   _____
   _____

9. Tell us more about your situation: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Please return the completed Transition of Care Questionnaire and Consent Form to Care Management in one of the following ways:

Mail: 3601 SW Murray Blvd.
Beaverton, OR 97005
Attn: Care Management

Email: CareManagement@Providence.org

Fax: 503-574-8171

PROVIDENCE Health Plan

Prior Authorization Request

****Chart Notes Required****

PROVIDENCE Medicare Advantage Plans
A division of Providence Health Assurance

TOC

Please fax this request to: 503-574-6464 or 800-989-7479
Please 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 Requests: http://www.americanimaging.net/goweb/ For Registration: Providence PIN #: 045-83169

Member Information	
Last Name:	First Name:
ID #:	DOB:
Address:	

Provider Information	
Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:
Servicing Facility:	TIN#:
Address:	NPI#:

Request Information	
ICD-10 Code(s):	
CPT Code(s):	
Requested Services: ☐ Office Visits, # of visits: _____ ☐ Surgery ☐ Diagnostic ☐ Facility Auth Only	Type of Service: ☐ Inpatient ☐ Outpatient Surgery ☐ Office Surgery ☐ Outpatient Diagnostics ☐ ASC
DOS:	**Date Span Requested:**
Comments:	

****REQUIRED**** Contact Information:	
Name:	Phone #:
Fax #:	Total # of pages faxed, including cover page:
☐ **In-Network Benefits being requested**	☐ **PLEASE EXPEDITE!** The provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy (CMS definition)

 November 14, 2018

FAX 503-574-8171 -OR- MAIL TO: PROVIDENCE HEALTH PLAN
PO BOX 4327 PORTLAND, OR 97208-4327

PROVIDENCE Health Plans

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

I 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 my care 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 information and related records

_____ Drug/alcohol diagnosis, treatment, or referral information

_____ Mental health information

_____ Genetic testing information

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 may be 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 test or 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):

Date: _____ **- 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:_____ **Date:**_____

(Individual)

- OR -

By:_____ **Date:**_____

(Individual's representative)

Relationship to member: Parent Legal guardian* Holder of Power of Attorney*

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