

MEDICAL CARE TRANSITIONAL BENEFITS REQUEST FORM

Transitional Medical Care Benefits are designed for:

Case File # _____

Participants or their eligible dependent(s) currently receiving medical care under a specific provider or benefit plan that if altered or compromised during this transition would threaten the recovery or well-being of the participant or dependent(s). Examples include but are not limited to: skilled nursing care, post surgical care or care for pregnancy.

To receive consideration for transitional medical care benefits coverage, the employee/dependent is required to **complete** and **sign Section I** of the request form. **Your signature authorizes the release of medical records related to the diagnosis and treatment of the medical condition listed in Section II. Any additional documentation from the attending physician needed to complete explanations of conditions stated in Section II must be submitted with this transitional form. These records are considered confidential and will be utilized by the Medical Transition Team to review the transitional treatment plan recommended by your physician for your (temporary) continuation of care or authorized alternatives as per your benefit policy. This request cannot be processed without the employees signature of release in Section I.**

SECTION I: TO BE COMPLETED BY EMPLOYEE

Employee Name: Last/First/Middle Initial _____		
Social Security # _____ Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child <input type="checkbox"/> Family <input type="checkbox"/> Medicare Supp. Cov.		
Daytime Phone # _____	Employee Date of Birth _____	
Current Health Plan _____		
Current Plan Election Name of HMO _____ Name of Selected Primary care Physician (Last/First/Middle Initial) _____		
<input type="checkbox"/> Traditional/Indemnity <input type="checkbox"/> PPO <input type="checkbox"/> POS - PCP Required <input type="checkbox"/> HMO		
Name of Employee/Dependent for whom transitional medical care is requested. Last/First/Middle Initial _____		Relationship to Employee _____
Date of Birth of Employee/Dependent for whom transitional medical care is required _____		
Name of Current Primary Care Physician _____	Last/First/Middle Initial _____	Office Phone # _____
Name of Referred or Specialist MD _____	Last/First/Middle Initial _____	Office Phone # _____
Other Insurance coverage:		
Insurance Name _____		Policy Holder Name _____
Plan Type _____	Insurance Phone # _____	Policy Holder Date of Birth _____
Social Security # _____		Policy # _____
Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child <input type="checkbox"/> Family <input type="checkbox"/> Medicare Supp. Cov. Effective from ____ to ____		
Employee/Dependent statement describing current medical status Condition: _____ _____		
Current Treatment Plan: _____		
Date of most recent visit: _____		Frequency of visits: _____
If conditions due to pregnancy, then estimated due date _____	Hospitalization or Surgery Planned _____	Scheduled Date _____
Name of Facility/Hospital where receiving treatment _____		

SECTION I continued on 2nd page

SECTION I (CONTINUED FROM PAGE 1) TO BE COMPLETED BY EMPLOYEE

Explanation for Request:

I authorize release of my medical records for purpose of Transitional Team review

Signature _____ Date _____

SECTION II: TO BE COMPLETED BY ATTENDING PHYSICIAN/SPECIALIST

Physician Name
Last/First/Middle Initial _____

Speciality _____ Hospital
Affiliation(s) _____

Street
Address _____

City _____ State _____ Physician
Phone # _____

Brief Explanation of medical status.
Please include copies of Medical Records if appropriate as well as your recommendation for transfer of services or care to a provider within the transitional plan network.

Date of last visit: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Treatment Plan/Recommendation (Rx): _____

Frequency and Duration of visits: _____

Could care be transferred to another Provider/Physician without compromise:

Yes No If no, why: _____

Physician Signature _____ Date _____

**SECTION III: TO BE COMPLETED BY PLAN UTILIZATION MANAGEMENT
TRANSITION COORDINATOR**

Approval Denial

Authorizing Signature _____ Date _____

Effective from _____ to _____ Authorization # _____

Please return to:

**Insurance Design Administrators
153 Bauer Drive
Oakland, N.J. 07436
Attention: Ute Madonna**