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: ❒ Single ❒ Husband/Wife ❒ Parent/Child ❒ Family ❒ Medicare Supp. Cov.

Daytime Phone # _____ Employee Date of Birth _____

Current Health Plan _____

Current Plan Election
❒ Traditional/Indemnity ❒ PPO
❒ POS - PCP Required ❒ HMO

Name of HMO _____ Name of Selected Primary care Physician (Last/First/Middle Initial) _____

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: ❒ Single ❒ Husband/Wife ❒ Parent/Child ❒ Family ❒ 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