WELLFLEET

Continuity of Care/Transition of Care Request Form

<u>Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation.</u> Please complete a separate form for each family member who needs to have care transitioned to another provider.

For assistance with completing this form, please call Wellfleet Customer Service at 1-800-633-7867 and they can assist you.

Once the form is complete, email to the Wellfleet Clinical Team at clinical@wellfleetinsurance.com or fax to (413)781-1958: Attn: Wellfleet Clinical Team.

Transition of Care

With Transition of Care, you may be able to continue to receive services for specified medical and behavioral conditions with health care providers who are not in the network used on your health plans network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 90 days after the effective date of your coverage.

Continuity of Care

With Continuity of Care, you may be able to receive services at in-network coverage levels for specified medical and behavioral conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. You must apply for Continuity of Care within 90 days of your health care provider's termination date. This is the date that he or she is leaving your plan's network.

How this works

You must already be under treatment for the condition identified on the Transition of Care/Continuity of Care request form.

- If the request is approved for medical or behavioral conditions:
  - –You will receive the in-network level of coverage for treatment of the specific condition by the health care provider for a defined period of time, as determined by Wellfleet.
  - –If your plan includes out-of-network coverage and you choose to continue care out-of-network beyond the time frame approved by Wellfleet, you must follow your plan's out-of-network provisions. This includes any precertification requirements.
  - –Transition of Care/Continuity of Care applies only to the treatment of the medical or behavioral condition specified and the health care provider identified on the request form. All other conditions must be cared for by an in-network health care provider for you to receive in-network coverage.
- The availability of Transition of Care/Continuity of Care:
  - –Does not guarantee that a treatment is medically necessary.
  - –Does not constitute precertification of medical services to be provided.
- Depending on the actual request, a medical necessity determination and formal precertification may still be required for a service to be covered.

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How To apply for Transition of Care/Continuity of Care coverage

Requests must be submitted in writing, using this Transition of Care/Continuity of Care request form. This form must be submitted at the time of enrollment, change in medical plan, or when your health care provider leaves the network on your health plan. It cannot be submitted more than 30 days after the effective date of your plan or your health care provider's termination. After receiving your request, Wellfleet will review and evaluate the information provided. Then, we will send you a letter informing you whether your request was approved or denied. A denial will include information about how to appeal the determination.

Fill out the form below completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation.

Plan/Group Number: ___________________________ Plan/Group Name: ____________________________

Student/Member Name:___________________________Student/Member Health Plan ID #: ________________ _____________

Student/Member ID Number: _______________________

Student/Member Date of Enrollment in Plan

Student/Member Home Address:

Street: ___________________________

City: _____________________________

State: ___________________________

Zip Code: _________________________

Student/Member Home Phone/Mobile: __________________________________

Student/Member Date of Birth:_____________________Allergies: _____________________________________

Preferred Phone #:______ ☐ Home☐ Work☐ Cell Secondary Phone #:____________ ☐ Home☐ Work☐Cell

Diagnosis for Continuity of Care (include pertinent history and physical findings): ___________________________
____

1. Do you have an upcoming appointment to see a specialist? Yes____No_____

If yes, please provide the applicable information below.

Specialist Type	Provider Name (Last and First)	Provider Phone #	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				

Infectious Disease Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for Pregnancy Due date: Hospital for delivery:				
Other: Please be specific				

2. Are you currently receiving any of the following services?____Yes _No___

If yes, please provide the applicable information below.

Services	Facility or Company, Medical or Behavioral Health Provider
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Other: Please be specific	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ___Yes __ No

   Date_______________Type of Surgery/Procedure __________________________

   Name/Phone Number of Physician performing surgery/procedure ___________________________________

   Hospital/Facility ____

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months?____Yes _No

   Reason ____ Hospital _________________________________

   Date(s) of Service ___________________________________

5. Other Needs ____

Continuity of Care/Transition of Care Request Form

<table>
<tr><td colspan="2">I hereby authorize the above provider to give the Wellfleet Clinical Team any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the Clinical Team may share information and discuss my care with my new Primary Care Physician/Medical Group under my Health Plan. I understand that I am entitled to a copy of this authorization form. I also authorize the Health Plan to leave confidential information on my voicemail at the following number(s) listed above. Please check all that apply:

☐ Home ☐ Mobile ☐ Do NOT leave confidential information on my voice mail</td></tr>
<tr><td>Signature of Patient if 18 or over:</td><td>Date:</td></tr>
<tr><td>Signature of Parent or Guardian if Patient is under 18:</td><td>Date:</td></tr>
</table>

Transition of Care/Continuity of Care requests will be reviewed within 10 business days of receipt. For new plans, review will occur within 10 days of the plan's effective date. Review for organ transplant requests may take longer than 10 days.

THE SECTION BELOW IS FOR WELLFLEET INTERNAL USE ONLY:

To Be Completed by Wellfleet Customer Service:

Name of the Wellfleet Customer Service Rep. completing this form: ___________________________________

Title of Wellfleet Customer Service Rep. completing this form: _______________________________________

Date Wellfleet Customer Service Rep. completed this form: ____

Name of Network(s) on Student/Member's Plan: ____

By looking on the network's provider finder tool, are there in-network providers who can provide the requested service(s) to the member? Yes____ No ____

If yes, please provide below, a screen shot from the provider finder look up tool of the in-network provider, name, and address.

To Be Completed by Wellfleet Clinical Reviewer:

Clinical Review Name: ____

Clinical Review Title: ____

Date of Clinical Review: ____

Continuity of Care Request Decision:

Approved: Yes________ No__________

IF Approved: Date of Approval: ____

IF Declined: Indicate the reason the COC request is not approved:
____

Add Additional Notes below, if applicable: