WELLFLEET

Continuity of Care/Transition of Care Request Form (Personal and Confidential)

Transition of Care (TOC)

You can apply to receive TOC when you become a new member of a Wellfleet benefit plan and you are being treated by a doctor (or other type of provider) who is not in the network used on the benefit plan. With TOC, you may be able to continue to receive services for specified medical and behavioral conditions with your out-of-network provider that you are in an ongoing course of treatment with at the plan's 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 TOC at time of 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 (COC)

You can apply to receive COC 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. You may be able to receive services at in-network coverage levels for specified medical and behavioral health conditions for up to 90* days. You must apply for COC within 90 days of the date you receive notice of your health care provider's termination date. This is the date that your provider is leaving your plan's network.

How the process works

You must already be under treatment for the condition identified on the Transition of Care/Continuity of Care Request Form (located on Wellfleet's website).

- 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 benefit 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 to the health care provider identified on the request form. All other conditions must be provided by an in-network health care provider for you to receive in-network benefit coverage.
- For Continuity of Care requests for a covered pregnant member already in a course of treatment with a provider, the continuity of care period shall extend through the postpartum period.

Note: The availability of Transition of Care/Continuity of Care does not guarantee that a treatment will be approved as medically necessary or constitute precertification of medical services to be provided. Please note that for some services, a medical necessity determination and formal precertification may still be required for a service to be covered. Please review your plan documents for details.

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, and be signed by the requesting provider. 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 after 90 days* of the date you received notice of your health care provider's termination., Once our review of the Form is complete, we will send you a decision letter, either approving or denying you or your provider's request.

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Fill out this form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member.

Plan/Group Number: ___________________________

Plan/Group Name: _____________________________

Student/Member Name:__________________________

Student/Member Date of Birth: ____________________

Student/Member Health Plan ID Number: _____________

Student/Member Date of Enrollment in Plan: __________

Student/Member Home Address:

Street: _________________________

City: ___________________________

State: _________________________

Zip Code: _________________________

Student/Member Home Phone/Mobile Phone: ________________________________

☐ Preferred Phone #:_________ ☐ Home☐ Work☐Cell Secondary Phone #:___________ ☐ Home☐ Work☐Cell

Allergies: ____

Diagnosis for Continuity of Care/Transition of Care (include pertinent history and physical findings): ____________

____

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 For Visit
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				

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1. 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 Name and Phone Number**
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)	

2. 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 ____

3. 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 ___________________________________

4. Other Needs ____

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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 voice mail at the following number(s) listed above. Please check all that apply:

☐ Home ☐ Mobile ☐ Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over:	Date:
Signature of Parent or Guardian if Patient is under 18:	Date:

Provider Information:

Name of treating provider: ____

Provider Telephone Number: ____

Provider Tax ID Number: ____

Provider Address (Street, City, State, Zip): ________________________________

If Wellfleet approves this request, provider agrees to the following terms:

-to provide the member's/patient's treatment and follow-up care

-to accept payment in full and not seek more payment from this patient other than the member/patient responsibility under the patient's plan of benefits (for example, copayment, deductibles or other out of pocket requirements)

-to share information on the member's/patient's treatment with us

-to use the network on the member's/patient's benefit plan for any referrals, lab work or hospitalization for services not part of the requested treatment

Signature of Treating Provider:

Date (MM/DD/YYYY):

Email the completed Form to the Wellfleet Clinical Team at clinical@wellfleetinsurance.com or fax to (413)781-1958: Attn: Wellfleet Clinical Team.

For assistance with completing this form, please contact **Wellfleet Customer Service at 1-800-633-7867**.

Continuity of Care/Transition of Care Request Form (Personal and Confidential)

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 Representative (if applicable):

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 Reviewer Name: ____

Clinical Reviewer Title: ____

Date of Clinical Review: ____

Continuity of Care/Transition of Care Request Decision:

Approved: Yes________ No__________

IF Approved: Date of Approval: ____

IF Declined: Indicate below the date of denial and the reason the COC/TIC request is not approved:

For approvals and denials, the Clinical Reviewer will send a letter to the member/patient and provider. **Add Additional Notes below, if applicable:**

***Note: Some states have unique Continuity of Care requirements and time frames. Please contact the Wellfleet Customer Service Team to review specific state requirements outlined in the Wellfleet Continuity of Care Policy.**