WELLFLEET STUDENT

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

This document explains how situations involving the need for continuation of care or transition of care are handled.

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 from the date of notice to you that your health care provider has terminated from the network used on your health insurance plan. (i.e., the date your provider leaves your plan's network).

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 physician (or other type of provider) who is not in the network used on the benefit plan. Under TOC, you may be able to continue to receive services for specified medical and/or behavioral conditions with an out-of-network provider, with whom you are undergoing treatment, 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.

How the process works

You must already be under treatment for the condition identified on the Continuity of Care/Transition 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 benefit provisions. This includes any precertification requirements.
  - Continuity of Care/Transition 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 handled by an in-network health care provider for you to receive an 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 Continuity of Care/Transition of Care options do 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 Continuity of Care/ Transition of Care Coverage:

Requests must be submitted in writing, using this Continuity of Care/Transition of Care request form, and be signed by the requesting provider. This form must be submitted at the time of enrollment, a change in medical plan, or when your health care provider leaves your health plan's network. In most instances, it needs to be submitted no more than 90 days* after the effective date of your plan or no more than 90 days* of the date you received notice that your healthcare provider terminated from the network. Once our review of the submitted 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. Complete a separate form for each family member.

Plan/Group Number: _____

Plan/Group Name: _____

Student/Member Name: _____

Student Member/Date of Birth (mm/dd/yyyy): _____

Student/Member Health Plan ID Number: _____

Student/Member Date of Enrollment in Plan (mm/dd/yyyy): _____

Student/Member Home Address: _____ *Street* _____ *City*

_____ *State* _____ *Zip*

Student/Member Phone: _____ Mobile ☐ (check box if preferred)

_____ Home ☐ (check box if preferred)

_____ Work ☐ (check box if preferred)

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 complete the applicable information below:

Specialist Type	**Provider Name (Last, 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 complete 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

   If yes, describe Type of Surgery/Procedure and the scheduled date: _____

   List the Name and Phone Number of Physician performing surgery/procedure:

   _____

   Name of Hospital/Facility: _____

3. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? Yes No

   Reason: _____

   Facility: _____

   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 Continuity of Care/Transition of Care. I understand that the Wellfleet 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 authorize the Health Plan to leave confidential information on voice mail at the following number(s) as listed above. Please check all that apply:

Mobile ☐ Home ☐ Work ☐ Do NOT leave confidential information on any device ☐

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 additional payment other than the member/patient responsibility under the patient's plan of benefits (e.g., copays, deductibles, coinsurance, etc.)
- To share information on the member's/patient's treatment with Wellfleet
- 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/yyy): _____

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 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. Reviews for organ transplant requests may take longer than 10 days.

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WELLFLEET INTERNAL USE ONLY:

To Be Completed by Wellfleet Customer Service Representative submitting the form (if applicable):

Name of Wellfleet Customer Service Rep.: _____

Title of Wellfleet Customer Service Rep.: _____

Date Wellfleet Customer Service Rep. completed this form: _____

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

Using the network's provider finder tool, are there in-network providers who can provide the requested service(s) to the Student/Member? Yes ☐ No

If yes, please provide a screenshot from the provider finder look-up tool of the in-network provider's name and address below:

To Be Completed by Wellfleet Clinical Reviewer:

Name of Clinical Reviewer: _____

Title of Clinical Reviewer: _____

Date of Clinical Review: _____

Continuity of Care/Transition of Care Request Decision: Approved ☐ Denied

If approved, list date of approval: _____

If denied, indicate below the date of denial and reason why the COC/TOC request is not approved:

For all approvals and denials, the Clinical Reviewer will send a letter to the member/patient and provider informing them of the decision. Add additional notes below, if applicable:

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

Reset Form