

# Understanding Transition of Care and Continuity of Care.

## Transition of Care

Transition of Care gives certain new UHC members the option to request extended coverage from their current out-of-network healthcare professional at network rates for a limited time. This extended coverage only applies for specific medical conditions until the safe transfer to a network health care professional can be arranged. Examples of covered medical conditions can be found on page 2 of this document. You must apply for Transition of Care no later than 30 days after the date your UnitedHealthcare coverage begins using the form beginning on page 4.

**Get help with understanding these health insurance terms and more on page 3.**

## Continuity of Care

Continuity of Care gives UnitedHealthcare members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time.

**Examples of covered medical conditions can be found on page 2 of this document.**

If your health care professional is leaving the UnitedHealthcare network, or if you are a new UnitedHealthcare member, you must apply for Continuity of Care or Transition of Care within 30 days of the health care professional's termination date or within 30 days from your effective date, using the form beginning on page 4.

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## How Transition of Care and Continuity of Care works:

You must already be under active and current treatment (see definition below) by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity of Care form below.

- Your request will be evaluated with consideration for applicable Federal law, State law and accreditation standards.
- If your request is approved for the medical condition(s) listed in your form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for a defined time frame, as determined by UnitedHealthcare. All other services or supplies must be provided by a network health care professional for you to receive network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame approved by UnitedHealthcare, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements.
- The availability of Transition of Care and Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required in order for a service to be covered.

## Examples of medical conditions that may qualify for Transition of Care and Continuity of Care:

- Pregnant and undergoing a course of treatment for the pregnancy.
  - Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select an in-network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery).
- Serious acute conditions in active treatment such as heart attacks or strokes.
- Other serious chronic conditions that require active treatment.

## Examples of conditions that do not qualify for Transition of Care and Continuity of Care:

- Routine exams, vaccinations and health assessments.
- Chronic conditions such as diabetes, arthritis, allergies, asthma, kidney disease and hypertension that are stable (except as required by state law).
- Minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries (except as required by state law).

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## Frequently asked questions:

**Q** What can I expect after the completed form is submitted?

**A** You will receive a written decision either approving or denying your request. We encourage you to find a doctor, healthcare professional or facility (like a hospital) in your network at **myuhc.com**.

**Q** If I am approved for Transition of Care and Continuity of Care for one medical condition, can I receive network coverage for a non-related condition?

**A** No. Network coverage levels provided as part of Transition of Care and Continuity of Care are for the specific medical conditions only and cannot be applied to another condition. If you are seeking network level of benefits for more than one medical condition, you will need to submit a separate request for each condition.

## Definitions:

**Transition of Care:** Gives certain new UnitedHealthcare members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time. This extended coverage only applies to specific medical conditions, until the safe transfer to a network health care professional can be arranged.

**Continuity of Care:** Gives UnitedHealthcare members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network.

**Network:** The facilities, providers and suppliers your health plan has contracted with to provide health care services.

**Out-of-network:** Services provided by a non-participating provider.

**Pre-authorization:** An assessment for coverage under your health plan before you can get access to medicine or services.

**Active course of treatment:** An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally an active course of treatment is defined as within the last 30 days, but is evaluated on a case-by-case basis.

See other health care and health insurance terms and definitions at **justplainclear.com**.

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# Transition of Care and Continuity of Care Form

This form is for all fully insured members except for members residing in California, Connecticut, New Jersey, New York, North Carolina or South Carolina.

**For behavioral health services, please contact your behavioral health carrier by calling the Customer Service phone number on your health plan ID card.**

**To complete this form:**

- Please make sure all fields are completed. When the form is complete, it must be signed by the member for whom the Transition of Care and Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for Transition of Care and Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date.
- A separate Transition of Care and Continuity of Care form must be completed for each condition for which you and/or your dependents are seeking Transition of Care and Continuity of Care.
- Please mail or fax the completed form, along with relevant medical records and information, within 30 days following the effective date of your UnitedHealthcare plan to:

**UnitedHealthcare**
**600 Airborne Parkway**
**Cheektowaga, NY 14225**
**Attn: Transition of Care/Continuity of Care Fax: 855-686-3561**

- After receiving your request, UnitedHealthcare will review and evaluate the information provided. Incomplete forms will be returned to the requestor. If the form is complete, we will send you a letter to let you know if your request was approved or denied. Completion of this form does not guarantee that a Transition of Care and Continuity of Care request will be granted.

| **Member Information** | | |
|---|---|---|
| ☐ New UnitedHealthcare member (Transition of Care applicant)<br>☐ Existing UnitedHealthcare member whose care provider terminated (Continuity of Care applicant) | | Provider Termination Date |
| Name (Person being treated) | UnitedHealthcare Member ID Number | Date of Birth (mm/dd/yyyy) |
| Address | City | State/ZIP Code |
| Home/Cell Phone Number | Work Phone Number | |
| Employer Name | Date of Enrollment in the UnitedHealthcare Plan (mm/dd/yyyy) | |
| Member's Relationship to Employee<br>☐ Self ☐ Spouse<br>☐ Dependent ☐ Other | Is the member currently covered by other health insurance carrier?<br>☐ Yes ☐ No<br>If yes, carrier name: | |
| **Authorization to release records:**<br>I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Transition of Care/Continuity of Care benefits under the plan. | | |
| Member's Signature/Parent or Guardian's Signature if Member is a Minor | | Date (mm/dd/yyyy) |

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| Care Provider Section: Your health care professional should complete the following information. | | |
|---|---|---|
| Name (Treating physician or other health care professional) | National Provider Identifier (NPI) or Tax ID Number (TIN) | Phone Number |
| Address | City | State/ZIP Code |
| Facility Name, NPI/TIN, Address, City, State | | Facility Phone Number |
| Date of Last Visit (mm/dd/yyyy) | Next Scheduled Appointment (mm/dd/yyyy) | Frequency of Visits |
| Diagnosis | Expected Length of Treatment | If Maternity: Expected Date of Delivery (mm/dd/yyyy) |

Please select 1 of the descriptions if it applies:

☐ Life-Threatening Condition ☐ Acute Condition ☐ Transplant ☐ Inpatient/Confined
☐ Upcoming Surgery ☐ Disabled/Disability ☐ Terminal Illness ☐ Ongoing Treatment

**Newborn members:** Coverage for newborn children begins at the moment of birth and continues for 30 days. You must select a network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

Is the treatment for an exacerbation of a previous injury or chronic condition? ☐ Yes ☐ No

**Current Condition and Associated Treatment Plan (include brief statement and all relevant CPT codes*)**

If these care needs are not associated with the condition for which you are applying for Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition. *attach additional clinical, as needed.

We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time-frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered. Please note the following:

For providers leaving our network: The terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any co-payment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional Date (mm/dd/yyyy)

CONFIDENTIALITY NOTICE: Information in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Any recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.

*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime, and may also be subject to a civil penalty for each violation.*

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We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

**Online:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**Phone:** Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة التعريف الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.