Scripps | Scripps Health Plan

**TRANSITION OF CARE REQUEST FORM**

**Scripps Health Plan UM**
**Fax: 858-260-5877**

**STEP 1**: Fill out these sections:

1. Section 1 – Employer Information
2. Section 2 – Subscriber and Patient Information: Scripps Health Plan Services (SHPS) plan information is on the front of the member ID card
3. Section 3 – Authorization: Read the authorization, then sign and date the form.

**STEP 2**: Give the form to the doctor/health care provider to complete Section 4.
**STEP 3**: **Fax** the completed form to Scripps Health Plan Utilization Management (UM) for review

Once we receive your completed form, we'll send you a letter explaining our decision.

If we approve your request, Scripps will cover ongoing care at the highest level of benefits from:

- An **out of network doctor willing to accept Scripps Health Plan Service's contracted rates**
- **Certain other health care providers** who have treated you

Here you'll find answers to commonly asked questions and things you should know about transition of care coverage:

**Q. What is transition of care (TOC) coverage?**
A. It is the policy of SHPS to provide transition of care for new enrollees who are undergoing an Active Course of Treatment from a nonparticipating provider. SHPS has established policies and procedures for the safe planned and unplanned transfer of care of new members with acute, serious chronic medical and/or mental health conditions who are currently receiving services from a nonparticipating medical and/or mental health provider to a participating provider when his/her employer changes health plans. Approved TOC coverage allows a member who is receiving treatment to continue treatment **for a limited time** at the highest plan benefits level. TOC coverage applies to these types of providers: medical and mental health providers, general and specialty practitioners, hospitals, and institutions licensed in California to deliver or furnish health care services.

**Q. What is an active course of treatment?**
A. An active course of treatment means you have begun a program of planned service with your doctor to correct or treat a diagnosed condition. To be considered for TOC coverage, treatment must have started before the enrollment date. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Any newly enrolled plan member that is in a course of treatment or is scheduled for a procedure can request to continue treatment with that provider for the following covered services:

- Acute Condition – Completion of covered-services shall be provided for the duration of the acute condition
- Serious Chronic Condition – Completion of covered-services shall not exceed 12-months from the date of enrollment in Scripps Health Plan
- A Pregnancy – Completion of covered-services shall be provided for the duration of the pregnancy
- Care of a Sick Newborn – Completion of covered services shall not exceed 12-months from the date of enrollment in Scripps Health Plan
- Performance of a Surgery – by a non-contracting provider is covered if the procedure is scheduled within the first 180-days of enrollment in Scripps Health Plan
- A Terminal Illness – Completion of covered services shall be provided for the duration of a terminal illness
- Behavioral Health/Substance Abuse – Contact SHPS Customer Service at **844-337-3700**

**Q. What other types of providers, besides doctors, can be considered for TOC coverage?**
A. TOC coverage may also apply to physical/occupational/speech therapists, and agencies that provide skilled home care services, such as visiting nurses. Providers considered for TOC coverage may vary by condition, as described above, in accordance with California law. California TOC coverage does not apply to durable medical equipment (DME) vendors or pharmacy vendors.

**Please note that filling out the TOC form does not guarantee requested services will be covered.**

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## 1. Employer Information

| Employer's Name (please print) | Employer Group Number | Plan effective date (required) |
|---|---|---|
| | | |

## 2. Subscriber and Patient Information

| | | | |
|---|---|---|---|
| Subscriber's Name (please print) | | Member ID Number | |
| Subscriber's Address | City | State | Zip |
| Patient's Name – *if different from Subscriber* (please print) | Relationship to Subscriber □Spouse □Child □Other | Sex | Date of Birth / / |
| Patient's Address – *if different from Subscriber* | City | State | Zip |
| Telephone number for Patient/Subscriber submitting request | Last date of treatment before beginning Scripps coverage (as applicable) | | |

## 3. Authorization

MEMBER DISCLAIMER/ AUTHORIZATION

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with SHPS. **If approved**, I understand that the authorization for coverage of services stated below will be valid for a **certain limited period of time**. I give permission for the healthcare provider to send any needed medical information and/or records to SHPS so a decision can be made.

| | |
|---|---|
| Patient's Signature (Required if Patient is 17 or Older) | Date (MM/DD/YYYY) |
| Parent's Signature (Required if Patient is 16 or Younger) | Date (MM/DD/YYYY) |

## 4. Provider Information – *This section to be completed by your physician*

Your patient has requested that SHPS cover care provided by you for a specific diagnosis and period of time. SHPS may contact you at the number provided below for additional information or to resolve your patient's request. Each case is reviewed with guidelines and criteria in place. If this TOC request is approved, SHPS will contact your office to discuss contracted rates.

| | |
|---|---|
| Name of treating doctor or other health care provider (please print) | Telephone Number |
| Contact name of office personnel to call with questions | Business Hours |
| Address of treating doctor or other health care provider (please print) | Tax ID Number |
| Signature of treating doctor or other health care provider | Date (MM/DD/YYYY) |

| | |
|---|---|
| Please provide all specific information to avoid delay in processing this request including, but not limited to:<br>- CPT code(s)<br>- Diagnosis code(s)<br>- Expected duration of treatment<br>- Treatment plan<br>- Surgical Date<br>- For pregnancy, expected delivery date | **Fax completed form and any supporting documentation you believe is appropriate to: 858-260-5877** |

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