UNITEDhealthcare®

APPLICATION FOR TRANSITION OF CARE

INSERT: United HealthCare Legal Entity
Claim Customer Service/Member Services
Mailing Address
City, State, Zip

United Healthcare
P.O. Box 30555
Salt Lake City, UT 84130

Employee/Applicant:

If you are currently under the care of a non-participating provider, there are a limited number of medical conditions that may qualify for Transition of Care. You must be enrolled in a benefit plan administered by United HealthCare. If United HealthCare Medical Management determines transitional care is medically necessary, specific treatment by a non-participating provider, for a limited period of time, may be covered at the network level of benefit. These services are subject to eligibility and coverage limitations at the time the medical care is administered.

To Apply:

ALL APPLICATIONS MUST BE SUBMITTED WITHIN THIRTY DAYS OF THE PLAN EFFECTIVE DATE

You should first complete Section 1 of this application.

If you answer **YES** to any of the questions in Section 1:

- Complete Section 2
- Ask your current physician to complete Section 3 and provide copies of relevant medical records.
- If there is more than one provider involved in your case, please provide a separate form for each one.
- You or your physician should send the completed application and medical records to United HealthCare, at the address above, prior to the effective date of coverage.
- If you are unable to apply for the Transition of Care prior to the plan effective date, you must select and contact a participating provider who must apply on your behalf within thirty days of the plan effective date.

If you answer **NO** to all the questions in Section 1, you may not be eligible for Transition of Care:

- Contact Claim Customer Service/Member Services (800 number on your ID card) for assistance in understanding Transition of Care and to assist you in selecting a participating provider.

SECTION 1	**TO BE COMPLETED BY APPLICANT**	
Is the patient in her last 3 months of pregnancy or delivered less than 6 weeks ago?	☐ YES	☐ NO
Is the patient pregnant and has been told this is a moderate or high risk pregnancy?	☐ YES	☐ NO
Is the patient currently undergoing treatment for cancer?	☐ YES	☐ NO
Is the patient undergoing treatment for an immunological disorder?	☐ YES	☐ NO
Is the patient undergoing treatment for severe or end-stage kidney disease?	☐ YES	☐ NO
Has the patient undergone a recent bone marrow or organ transplant, or on the waiting list to obtain an organ?	☐ YES	☐ NO
Is the patient currently receiving mental health treatment?	☐ YES	☐ NO
Is the patient currently receiving substance abuse treatment?	☐ YES	☐ NO

- If you have answered YES to any of these questions, please complete Section 2 and have your provider complete the rest of this form along with any pertinent medical records and return it to the United HealthCare address listed above.
- If you have answered NO to all of these questions you may not be eligible for Transition of Care. You need to select a participating provider to obtain the highest level of benefit. Please contact Claim Customer Service/Member Services for assistance in identifying a participating provider or in understanding Transition of Care.

SECTION 2	**TO BE COMPLETED BY APPLICANT**	
Employee Name		Social Security Number
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name		Plan Effective Date
Patient Name		Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)		
Are you currently covered by: ☐ Medicare ☐ Medicaid	Are you currently covered by other insurance? ☐ YES ☐ NO If yes, which company?	

Authorization to release records:

I authorize all providers and other medical professionals or institutions to provide United HealthCare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition of Care under the new plan.

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor — Date — **OVER**

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Physician:

Please fill out and check the entire form for completeness before submission to United HealthCare.

SECTION 3	TO BE COMPLETED BY PROVIDER CURRENTLY TREATING CONDITION	
Provider Name	Provider Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	Is treatment for an exacerbation of a previous injury or chronic condition? ☐ YES ☐ NO	
Current Treatment/Comments		
Signature of Physician		Date

SECTION 4	FOR INTERNAL USE ONLY BY UNITED HEALTHCARE
Medical Management Representative's Name	Transition of Care: ☐ Approved ☐ Not Approved (please document reason below)
Comments	
Medical Management Representative's Signature	Date