TRANSITION OF CARE APPLICATION

Dear MedStar Select Plan Member:

Thank you for joining the MedStar Select Plan.

You may currently be receiving services from healthcare providers that are not part of the MedStar Select Provider Network. An approved Transition of Care request allows you, as a new member, to continue care for a medical condition, under certain circumstances and for a specified period of time, with a specialist or at a hospital or facility outside of the MedStar Select Provider Network. Transition of Care is intended primarily for members who are in active, ongoing treatment with a non-participating provider and whose treatment will continue for a specific period of time following enrollment in MedStar Select.

If you have any questions about your benefits or services, please contact one of our MedStar Select Member Services Representatives at 855.242.4872, Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. Our representatives are available to help you find a doctor or facility in your area that is part of our comprehensive network of leading physicians and hospitals.

If you would like to submit a request to continue treatment with your current provider for a current, ongoing medical condition, please complete this Transition of Care request. Completed requests must be sent within 15 days after the effective date of your coverage under MedStar Select. Incomplete information will delay the Transition of Care review process. Mail the completed form to:

Attention: Clinical Management
MedStar Select Plan
600 Grant Street
24th Floor
Pittsburgh, PA 15219

If you have questions about completing this form, please contact one of our MedStar Select Member Services Representatives for assistance at 855.242.4872. TTY users should contact 855.250.5604. If you have been designated as a MedStar Select Plan member's personal representative to act on their behalf in discussing their health information and benefit coverage, please include the date that the Personal Representative Designation Form (PRDF) was sent to the MedStar Select Plan. If you need a copy of a PRDF, you may obtain one by calling a Member Services Representative.

TO BE COMPLETED ONLY BY MEMBERS WHO ARE REQUESTING TRANSITION OF CARE

Please complete a separate form for each covered dependent.

Self O **Spouse O** **Other O**

Member Name	
Member Address	
Member ID #	Leave blank if you have not yet received your member ID number.

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Daytime Phone #	
Evening Phone #	
Date of Birth	
Social Security #	

Reason for Requesting Transition of Care

I am requesting Transition of Care to continue treatment for the following illness(es), condition(s) or healthcare service(s) (be specific):

____

____

About the member whose records are being requested:	
Member Name	**Member ID**
	Leave blank if you have not yet received your member ID number.

Protected Health Information (PHI) Disclosure Consent Form

If you are completing and signing this form for a member who is a minor or a covered dependent who is legally incompetent, provide your name, address, and relationship to the member.

Name: ____

Address: ____

City/State/Zip: ____

Phone Number: ____

If applicable, relationship to the member: ____

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Authorized Healthcare Providers

To review your request, we will need to ask the provider(s) whom you identify below to disclose protected health information (PHI) from your medical records and/or charts. MedStar Select Plan will respect your privacy and keep your records properly protected as directed by HIPAA (Health Insurance Portability and Accountability Act) regulations.

List the providers from whom we may obtain your PHI:			
Provider Name:			
Provider Address:			
City:			
State:			
Zip:			
Phone Number:			
Fax Number:			

I,_____________________________, authorize the providers I've named to disclose my PHI to the Medical Management Department at MedStar Select Plan, my health insurance carrier. I understand that MedStar Select Plan's Medical Management Department will review my PHI as part of the Transition of Care process.

If you are requesting Transition of Care, check each box to indicate that you have read and understand the content. Please sign and date the form.

☐ Purpose of Disclosure

The purpose of this request and consent for disclosure is to allow MedStar Select Plan to receive all pertinent PHI needed to review and make a decision concerning this request for Transition of Care.

☐ Expiration of Consent

The use of the consent of disclosure of the PHI in this form expires 60 days from the date of the member's signature below.

☐ Need for Renewal of Consent

If I do not revoke this consent, I understand that it will expire on the expiration date indicated below. If I wish to extend the consent, I must renew the consent by completing a new consent form.

☐ Right to Revocation

I understand that I have the right to revoke this consent at any time. I understand that in order to revoke this consent, I must do so in writing and submit my written revocation to MedStar Select Plan Member Services Department and to the healthcare provider(s) indicated on this form. I understand that this revocation will not apply to information that has already been released in response to this consent.

☐ Right to Retain a Copy of this Consent

Please check here if you are not making a copy of this consent form for your own records, and wish to receive a copy from MedStar Select Plan network. I understand that I have the right to retain or receive a copy of this consent.

Signature____ Date_________________