

# Understanding Transition of Care and Continuity of Care

For members of Connecticut UnitedHealthcare and Oxford fully insured plans

## New members (Transition of Care)

New members may request benefits for treatment received from their current, out-of-network health care provider at the network benefit level for a short period of time so they may transition to a network provider.

Transition of Care (TOC) is available to members undergoing a course of treatment for a life threatening, degenerative or disabling condition or disease when the provider agrees to accept network rates and follow our policies and procedures.

## When your provider leaves the network (Continuity of Care)

Members in an ongoing course of treatment may request Continuity of Care (COC) from their current health care provider if the provider leaves their health plan network and is now considered an out-of-network provider. The provider will accept the prior network rates and follow our policies and procedures.

## How to make a request

Members may use the form beginning on page 4 or call the number on your health plan ID card for assistance with requesting TOC or COC.

## How Transition of Care and Continuity of Care works

To be eligible, you must already be under active and current treatment by the identified out-of-network provider for the condition identified on the TOC and COC form below.

- Your request will be evaluated based on 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 provider for:
  - up to 90 days from the effective date of coverage for new members,
  - up to 90 days from the date the provider has left the health plan network, and
  - if the member is in the second or third trimester of a pregnancy, through delivery and any post-partum services directly related to the delivery
- After this time, network coverage ends. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame we approve, you must follow your plan's out-of-network requirements, including any prior authorization requirements.
- All other services or supplies must be provided by a network provider for you to receive network coverage levels
- If your plan does not include out-of-network coverage, you can call the number on your health plan ID card for assistance

- The availability of TOC and COC 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 for a service to be covered.
- Continued treatment with a provider is not available if the provider was terminated for fraud, imminent harm to patient care or final disciplinary action by a state board or agency that impairs the provider's ability to practice.

## **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, including post-partum care
  - You must notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan. We encourage you to select an in-network pediatrician for your baby's care.
- 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 6 to 8 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
- Minor illnesses such as colds, sore throats and ear infections

# **Frequently asked questions**

## **How can I find a new network health care provider?**

You can call the phone number on your health plan ID card.

## **If my request is approved, how long will I have to transition to a new network health care provider?**

Services from the approved out-of-network health care provider will be authorized at the network level of benefits for up to 90 days from the effective date of coverage for new members receiving TOC. COC services will be authorized for up to 90 days from the date the provider left the network or until care has been completed or transitioned to a participating health care professional, whichever comes first. If a member is in the second or third trimester of a pregnancy, network coverage is available through delivery and any post-partum services directly related to the delivery.

## **If my request is approved for one medical condition, can I receive network coverage for a non-related condition?**

Network coverage levels provided as part of TOC and COC 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, please complete a separate request for each specific condition.

## **Behavioral health support**

For behavioral health services, please call your behavioral health carrier at the phone number for members on your health plan ID card.

## To complete this form:

- Please make sure all fields are completed, including provider's signature
- When the form is complete, it must be signed by the member for whom the TOC or COC is being requested. If the patient is a minor, a guardian's signature is required
- It is recommended that you request
  - TOC once you are eligible for benefits
  - COC when your provider is no longer in-network
- A separate TOC and COC Form must be completed for each condition for which you and/or your dependents are seeking TOC and COC

Please send the completed form, along with relevant medical records and information to:

**Fax: 1-855-686-3561 or Mail: UnitedHealthcare/Oxford**

**600 Airborne Parkway**

**Cheektowaga, NY 14225**

**Attn: Transition of Care/Continuity of Care**

- After receiving your request, we 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 request does not guarantee that a TOC or COC request will be granted.

# Transition of Care and Continuity of Care Form

This form is for all fully insured members covered under a Connecticut insurance policy.

## Member information

New UnitedHealthcare/Oxford member (Transition of Care) Existing UnitedHealthcare/Oxford member whose care provider terminated (Continuity of Care)		Provider Termination Date
Name (Person being treated)	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 Plan (mm/dd/yyyy)	
Member's Relationship to Employee Self   Spouse   Dependent   Other	Is the member currently covered by other health insurance carrier? Yes   No   If yes, carrier name:	

### Authorization to release records:

I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare/Oxford 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 and if approved, coverage of 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	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Hospital	Hospital 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

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

### Current and Associated Treatment(s)/Comments (include all relevant CPT codes)

If these care needs are not associated with the condition for which you are requesting for Transition of Care or Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care Form for each condition.

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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 (1) to provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, (2) to follow our policies and procedures, (3) upon request, to share information regarding the member's treatment with us, (4) if applicable, to 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, to request any required prior approval before the services are rendered. If coverage at the network benefit level is available, you agree to accept our payment together with any copayment, 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 from the member, us, or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge. **Any controversy or claim arising out of or relating to this agreement shall be resolved solely by confidential arbitration administered by the American Arbitration Association under its Commercial Arbitration rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.**

- 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 rates and reimbursement rules are based on your participation agreement.
- For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level for up to 90 days. Payment will be on a fee-for-service basis at 100% of the Medicare applicable rate using the participating regional fee schedule based on the service location along with our reimbursement rules.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

Signature of Health Care Professional

Date (mm/dd/yyyy)

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UnitedHealthcare and Oxford comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card Monday through Friday, 8 a.m. to 6 p.m. ET. TTY users can dial 711.

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。

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

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