Harbor Health

Request for Continued Access to Providers

Please complete this form if you are currently receiving ongoing medical care from providers that are not in-network under your new health plan or have recently terminated from the Harbor Health Insurance Company (HHIC) network. In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

SELECT REQUEST TYPE (PLEASE CHECK ONE):

☐ TRANSITIONING OF CARE (NEW TO HHIC)

☐ CONTINUITY OF CARE (SPECIAL CIRCUMSTANCES, SWITCHING FROM ONE PROVIDER TO ANOTHER, PROVIDER GROUPS/FACILITIES TERMINATING)

GROUP NAME	GROUP NUMBER	
SUBSCRIBER NAME	MEMBER ID	DATE OF BIRTH

PATIENT INFORMATION

NAME		DATE OF BIRTH	RELATION TO SUBSCRIBER
ADDRESS	CITY	STATE	ZIP CODE

MEDICAL OR BEHAVIORIAL HEALTH

DIAGNOSIS/TREATMENT PLAN

PROVIDER INFORMATION

NAME	NPI ID #
PHONE #	FAX #
ADDRESS	
DATE OF LAST VISIT	NEXT VISIT

PLEASE CHECK AS APPLICABLE

☐ PREGNANCY OR UNDERGOING COURSE OF TREATMENT FOR PREGNANCY	ESTIMATED DUE DATE
☐ SURGERY SCHEDULED OR RECENTLY PERFORMED	DATE OF SURGERY
☐ UNDERGOING POSTOPERATIVE CARE	DATE OF POST-OP CARE RECEIPT
☐ TRANSPLANT LIST	PLEASE PROVIDE COPY OF APPROVAL LETTER
☐ PHYSICIAN APPOINTMENT SCHEDULED	DATE OF APPT
☐ UNDERGOING A COURSE OF TREATMENT FOR SERIOUS AND COMPLEX CONDITION	DATES OF FREQUENCY AND DURATION
☐ UNDERGOING INSTITUTIONAL OR INPATIENT CARE FROM THE PROVIDER	DATES RANGE OF INPATIENT STAY
☐ HAVING BEEN DETERMINED TO BE TERMINALLY ILL	DATE DECLARED TERMINALLY ILL

PROVIDER SPECIALTY (PLEASE CHECK ONE)

☐ MD/DO (MEDICAL DOCTOR/DOCTOR OF OSTEOPATHIC MEDICINE)
☐ PHD (DOCTOR OF PHILOSOPHY)
☐ LCSW (LICENSED CLINICAL SOCIAL WORKER)
☐ LPC/LCPC (LICENSED PROFESSIONAL COUNSELOR/LICENSED CLINICAL PROFESSIONAL COUNSELOR)
☐ OTHER (DESCRIBE)

I hereby authorize Harbor Health Insurance Company or designee to obtain any information and medical records from the above physician(s)/provider(s) in connection with making an informed decision regarding my request for Treatment in Progress (Transitional Care benefits) under my health plan. I understand that I am entitled to a copy of this Authorization Form.

PRIMARY PHONE #	SECONDARY PHONE #
SIGNED (PATIENT OR GUARDIAN)	DATE

Please return completed form to:

Fax To: (512) 271-4493
Attn: UM Team
Harbor Health Insurance Company
P.O. Box 211262
Eagan, MN 55121