Harbor Health Request for Continued Access to Providers

Transisition Of Care Form

Please complete this form if the patient is 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 patient to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. Please have provider(s) fax preauthorization form to (512) 271-4493.

SELECT REQUEST TYPE (PLEASE CHECK ONE):

☐ TRANSITIONING OF CARE (NEW TO HHIC) ☐ CONTINUITY OF CARE (PROVIDER OR FACILITY LEAVING NETWORK)

SUBSCRIBER NAME		
GROUP 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/ ADDITIONAL INFORMATION

PROVIDER INFORMATION

NAME	NPI ID #	TAX ID #	
PHONE #	FAX #		
ADDRESS	CITY	STATE	ZIP CODE
DATE OF LAST VISIT	DATE OF 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	POST-OP CARE DATES
☐ TRANSPLANT LIST	PLEASE PROVIDE COPY OF APPROVAL LETTER
☐ PHYSICIAN APPOINTMENT SCHEDULED	DATE OF APPT
☐ UNDERGOING A COURSE OF TREATMENT FOR SERIOUS AND COMPLEX CONDITION	
☐ UNDERGOING INSTITUTIONAL OR INPATIENT CARE FROM THE PROVIDER	
☐ HAVING BEEN DETERMINED TO BE TERMINALLY ILL	DATE DECLARED TERMINALLY ILL

PROVIDER SPECIALTY (PLEASE CHECK ONE)

☐ MEDICAL DOCTOR & SPECIALITY - ADD SPECIALTY
☐ PHD
☐ 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:

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