HARBOR HEALTH INSURANCE COMPANY (HHIC)
TRANSITION & CONTINUITY OF CARE
PATIENT REQUEST FORM - INSTRUCTIONS

TRANSITION OF CARE COVERAGE

If you are a new member enrolling onto a Harbor Health Plan and are currently seeing a non-contracted provider, you may be eligible for Transition of Care ("TOC") coverage in certain circumstances. If your TOC request is approved, Harbor will provide coverage for your non-contracted provider for a limited period of time, subject to your cost share responsibility outlined in your Schedule of Benefits. For additional information, reference www.harborhealth.com and the *Transition & Continuity of Care Member Guide*. **NOTE: Until Harbor Health has completed a review and issued an approval for your TOC request, you will be responsible for the full cost of any non-emergency care you receive from the out-of-network Provider.**

CONTINUITY OF CARE COVERAGE

If you are undergoing a course of treatment from a Network Physician, Provider or facility at the time that Network Physician's, Provider's or facility's contract terminates with us for any reason, except for medical competence or professional behavior, you may be entitled to continue that care at the Network Benefit level for a limited period of time. **NOTE: Until Harbor Health has completed a review and issued an approval for your COC request, you will be responsible for the full cost of any non-emergency care you receive from the out-of-network Provider.**

WHO SHOULD COMPLETE THIS FORM

The individual ("Patient") requesting this continuance of medical services should be 18 years old or older. If the individual seeking ongoing medical care is 17 years old or younger, that Patient's parent or legal guardian should complete this to ensure accuracy and completeness.

FIELD DEFINITIONS

- **Subscriber:** The individual who is the primary insurance holder. The Patient and Subscriber may be the same person.
- **Patient:** The individual for whom the continuance of medical services by a Provider.
- **Patient Insurance ID:** The ID number found on the Harbor ID Card, also known as a Member ID.
- **Provider:** The medical professional who the Patient wishes to continue seeing for ongoing care.

SECTION INSTRUCTIONS

- **Subscriber Information & Patient Information Sections:** Complete the *Subscriber Information* section. If the Patient is not the Subscriber, complete all information in the *Patient Information* section.
- **Provider Information & Provider Specialty Sections:** Complete all information for the Provider that is being requested for ongoing medical services. For medical doctor, indicate the specialty such as orthopedics, pediatrics, etc. Consult with your provider if necessary.
- **Medical or Behavioral Health Section:** To assist in the review, complete all medical information, conditions, and upcoming dates.
- **Authorization and Signature Section:** Complete the contact information and sign the form.

SUBMIT COMPLETED FORM

Print the completed form and fax or mail to Harbor Health using the information at the bottom of the form.

Harbor Health

Transition & Continuity of Care Patient Request Form

COMPLETING THIS 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. *For additional information, reference www.harborhealth.com and the Transition of Care Member Guide.*

NOTE: Until Harbor Health has completed a review and issued an approval for your TOC request, you will be responsible for the full cost of any non-emergency care you receive from the out-of-network provider.

SELECT REQUEST TYPE (PLEASE CHECK ONE)

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

SUBSCRIBER INFORMATION

SUBSCRIBER NAME	SUBSCRIBER INSURANCE ID	DATE OF BIRTH	
ADDRESS	CITY	STATE Arkansas	ZIP CODE
EMAIL ADDRESS			

PATIENT INFORMATION (Complete if different from Subscriber)

PATIENT NAME	PATIENT INSURANCE ID	DATE OF BIRTH	RELATION TO SUBSCRIBER
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS			

PROVIDER INFORMATION

NAME	NPI ID #	TAX ID #	
PHONE #	FAX #		
ADDRESS	CITY	STATE Alaska	ZIP CODE
DATE OF LAST VISIT	DATE OF NEXT VISIT		

PROVIDER SPECIALTY (PLEASE CHECK ONE)

☐ MEDICAL DOCTOR & SPECIALITY (**INDICATE SPECIALTY**)
☐ PHD
☐ LCSW (LICENSED CLINICAL SOCIAL WORKER)
☐ LPC/LCPC (LICENSED PROFESSIONAL COUNSELOR/LICENSED CLINICAL PROFESSIONAL COUNSELOR)
☐ OTHER (DESCRIBE)

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Transition & Continuity of Care Patient Request Form

MEDICAL or BEHAVIORIAL HEALTH

DESCRIBE THE CONDITION AND CARE BEING REQUESTED

PLEASE CHECK AS APPLICABLE AND INCLUDE RELATED INFORMATION

☐ 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

AUTHORIZATION and SIGNATURE

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.

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

Return send completed form via either of the following methods:

Fax
(512) 271-4493 | Attn: UM Team

Mail
Harbor Health Insurance Company
Attn: UM Team
P.O. Box 211262
Eagan, MN 55121

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