



## 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](http://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.



## 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](http://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	
				ZIP CODE	

### PATIENT INFORMATION (Complete if different from Subscriber)

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

### PROVIDER INFORMATION

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

### PROVIDER SPECIALTY (PLEASE CHECK ONE)

<input type="checkbox"/> MEDICAL DOCTOR & SPECIALITY ( <b>INDICATE SPECIALTY</b> )
<input type="checkbox"/> PHD
<input type="checkbox"/> LCSW (LICENSED CLINICAL SOCIAL WORKER)
<input type="checkbox"/> LPC/LCPC (LICENSED PROFESSIONAL COUNSELOR/LICENSED CLINICAL PROFESSIONAL COUNSELOR)
<input type="checkbox"/> OTHER (DESCRIBE)



**MEDICAL or BEHAVIORIAL HEALTH**

DESCRIBE THE CONDITION AND CARE BEING REQUESTED
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PLEASE CHECK AS APPLICABLE AND INCLUDE RELATED INFORMATION

<input type="checkbox"/> PREGNANCY OR UNDERGOING COURSE OF TREATMENT FOR PREGNANCY	ESTIMATED DUE DATE
<input type="checkbox"/> SURGERY SCHEDULED OR RECENTLY PERFORMED	DATE OF SURGERY
<input type="checkbox"/> UNDERGOING POSTOPERATIVE CARE	POST-OP CARE DATES
<input type="checkbox"/> TRANSPLANT LIST	PLEASE PROVIDE COPY OF APPROVAL LETTER
<input type="checkbox"/> PHYSICIAN APPOINTMENT SCHEDULED	DATE OF APPT
<input type="checkbox"/> UNDERGOING A COURSE OF TREATMENT FOR SERIOUS AND COMPLEX CONDITION	
<input type="checkbox"/> UNDERGOING INSTITUTIONAL OR INPATIENT CARE FROM THE PROVIDER	
<input type="checkbox"/> 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