Transition Coverage Request

ECHS Category - TCRF

Personal and confidential

This form applies to fully insured commercial HMO members in California.

Here's the form you requested for transition-of-care coverage from the health plan. If we approve your request, the health plan will cover ongoing care at the highest level of benefits from:

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition-of-care coverage

You'll find answers to commonly asked questions about transition-of-care coverage on the other side of this form. You should read them before filling out this form.

Transition-of-care coverage does not apply if your provider is in the plan's network (participating). The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

How to complete the form and get it to us

Step 1**:** Fill out these sections:

1. Section 1 - Group or Employer Information.
2. Section 2 - Subscriber and patient Information: Plan information is on the front of your ID card.
3. Section 3 - Authorization: Read the authorization, then sign and date the form.

Step 2**:** Give the form to the doctor/health care provider to complete Section 4.

Step 3**:** **Fax** the completed form to us for review. You should complete one form for each health care provider.

Fax medical requests to 1-859-455-8650.
Fax mental health/substance abuse requests to 1-888-463-1309.

Be sure to complete all fields on page 4 before you submit this request form.
Your request will be answered faster that way.

Transition of care coverage questions and answers

California Commercial HMO Fully Insured Products

Q. What is transition-of-care (TOC) coverage?

A. TOC coverage is temporary. You can get TOC when you become a new member of a medical benefits plan or change your plan, and you are being treated by a doctor who is not in the plan's network. TOC coverage can also apply when your doctor leaves the plan's network or changes network status. Approved TOC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level. TOC coverage applies to these types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to deliver or furnish health care services. Examples of individual practitioners include doctors, psychiatrists licensed therapists, and qualified autism service providers, professionals or paraprofessionals.

Q. What is an active course of treatment?

A. An active course of treatment means you have begun a program of planned service with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course of treatment examples may include but are not limited to:

- Pregnancy - is the three trimesters of pregnancy and the immediate postpartum period.
    - Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
    - An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, **completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later**.
- An acute condition that involves the sudden onset of symptoms due to an illness, injury, serious mental illness or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for the duration of the acute condition.
- Previously scheduled surgery or other procedure authorized by the plan as part of a documented course of treatment. The documentation must show that the provider recommends the treatment to occur within 180 days of the provider's contract termination date or within 180 days of the effective date of a newly covered enrollee.
    - Need more than one surgery
    - Have recently had surgery
- A terminal illness that is an incurable or irreversible condition and that has a high probability of causing death within one year or less. Completion of covered services will be provided for the duration of the terminal illness.
- An on-going or disabling medical condition or serious mental illness due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services will be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan, in consultation with the member, the nonparticipating or terminated provider, and consistent with good professional practice. Coverage will not exceed 12 months from the contract termination date or 12 months from the effective date of a newly covered enrollee.
- Are in an ongoing treatment plan, such as chemotherapy or radiation therapy
- Any services related to the care of a child ages 0-36 months, up to 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
- May need or have had an organ or bone marrow transplant

To be considered for TOC coverage, treatment must have started before the enrollment or re-enrollment date, or before the date your doctor left the health plan's network, or before the date the doctor's network status changed.

Q. What other types of providers, besides doctors, can be considered for TOC coverage?

A. TOC coverage may also apply to physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services, such as visiting nurses. Providers considered for transition coverage may vary by condition, as described above, in accordance with California law. California TOC coverage does not apply to durable medical equipment (DME) vendors or pharmacy vendors.

Transition of care coverage questions and answers

California Commercial HMO Fully Insured Products (continued)

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for California TOC coverage?

A. If you're receiving treatment, the procedure or service must be a covered benefit. Your doctor must also agree to accept the terms outlined in this TOC Request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're currently receiving treatment (as described above), you may still be able to visit your PCP, even if he/she leaves the network. If not, you may need to select a new PCP in the health plan's network. Talk to your PCP so that he/she can help you with your future health care needs.

Q. How do I sign up for TOC coverage?

A. Contact the Member Services number on your member ID card. You must submit a TOC Request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the network
- Within 90 days of a doctor's network status change

Q. How will I know if my request for TOC coverage is approved?

A. You will receive a letter by U.S. mail. The letter will say whether or not you are approved.

Q. What if I have an Aexcel or plan sponsor specific network plan?

A. If we approve your TOC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health phone number.

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☐ **Medical** ☐ **Mental health/substance abuse**

Please indicate above whether this request is for medical treatment or mental health/substance abuse treatment.

1. Group or employer information (Note: Complete a separate form for each member and or provider.)

Group or employer's name (please print)	Plan control number	Plan effective date **(required)**

2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID number	
Subscriber's address (please print)		
Patient's name (please print)	Birthdate *(MM/DD/YYYY)*	Telephone number
Patient's address (please print)	Plan type/product	
Telephone number for patient/subscriber submitting request (Business hours, 9 a.m. – 5 p.m.)		

3. Authorization

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain limited period of time. I give permission for the health care provider to send any needed medical information and/or records to the health plan so a decision can be made.

Patient's signature (**required** if Patient is 17 or Older)	Date *(MM/DD/YYYY)*
Parent's signature (**required** if Patient is 16 or Younger)	Date *(MM/DD/YYYY)*

4. Provider information

Name of treating doctor or other health care provider (please print)	Telephone number
Contact name of office personnel to call with questions	
Address of treating doctor or other health care provider (please print)	Tax ID number
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

Please provide all specific information to avoid delay in the processing of this request.	

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation." Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not to seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use the health plan' network for any referrals, lab work or hospitalizations for services not part of the requested treatment.

Misrepresentation: Attention California residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Aetna and its affiliates comply with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna and its affiliates provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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DMHC written notice of availability of language assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน