Transition of Care Request Form

Purpose of Transition of Care

The Transition of Care Program provides a process that allows members to receive assistance in transferring their specific care needs when they are a new enrollee to the LifeConnections or LifeConnections Plus Savings plan, or their current SHCA provider is no longer contracted with the plan.

To avoid gaps in your treatment or charges from using non-participating doctors and/or ancillary services, please submit your Transition of Care Request Form as soon as you enroll or become aware of your transition of care needs. If you choose to continue care outside of the SHCA network without prior authorization for the service, the services will be considered not covered by the plan, and you will be responsible for the full cost of the service. Please call our Stanford Member Service Specialists at (844) 845-8078 with any questions.

Please Note: If you require ongoing care for any chronic condition (and you are not in an acute phase of your illness or are requiring a special course of treatment), you should select an in-network provider to meet your ongoing healthcare needs and you do not need to complete this form. If you need assistance selecting a new provider, you should contact Stanford Member Services at (844) 845-8078.

Completing the Transition of Care Request Form

We encourage you to fill out the Transition of Care Request Form or call if you think your health care needs require the assistance of our clinical team to assess your needs and determine when and to whom your treatment can be safely transitioned. Transition of Care requests occur either when a member is new to our plan or when a currently treating plan physician is no longer contracted with our plan. Members who have unique transition of health care needs requiring Transition of Care assistance may have the following types of health care conditions:

- Undergoing chemotherapy or radiation treatment for cancer
- Diagnosed with a terminal illness
- Waiting for a transplant or already working with a doctor towards a transplant
- Hospitalized at the time of the effective date of your new plan
- Receiving treatment for certain other acute or serious chronic conditions

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, you must:

- Call SHCA at (844) 845-8078 or email the Transition of Care form to cmreferrals@stanfordhealthcare.org to request transition of care consideration as soon as possible.
- If you choose to continue care outside of the SHCA network without a prior approval for the services, these services will be considered not covered by the plan and you will be responsible for the full cost of the service.

Transition of Care Request Form

To help ensure that your care is not disrupted, please complete the entire form below as soon as possible. If you are changing plans and your current provider is in the SHCA network, you do not need to complete this form.
Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name: _____

Subscriber's ID#: _____

Subscriber's Employer: _____ Date Active with LC/LCPS plan: _____

Patient's Name: _____ Relationship to Subscriber: _____

Date of Birth: _____ Allergies: _____

Preferred Phone #: _____ Home/Work/Cell; Secondary Phone #: _____ Home/Work/Cell

Name of Terminating Insurance Plan: _____ Type of Terminating Plan: ○ HMO ○ PPO ○ EPO ○ OTHER

Are You a New Enrollee to LifeConnections/LifeConnections Plus Savings? ◉ YES ○ NO

Name of Medical Group with Terminating Plan: _____

Name of New SHCA Provider: _____

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For Network Disruption (Provider or Hospital has terminated from the SHCA Participating Provider Network) please provide the name of the terminating Hospital or Provider: _____

Diagnosis (include pertinent history and physical findings):_____

_____

_____

_____

_____

_____

_____

_____

1. Do you have an upcoming appointment to see a specialist? ○ **Yes** ◉ **No**

If Yes, please provider the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Cancer or Blood Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for Pregnancy Due Date:				Hospital for delivery:
Other: Please be specific				

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2. Are you currently receiving any of the following services: ◉ **Yes** ○ **No**

If Yes, please provide the applicable information below:

Services	**Facility or Company, Medical or Behavioral Health Provider**
IV Medication/Chemotherapy	
Oxygen	
Clinical laboratory	
Physical/Rehab Therapy	
Radiation Therapy	
Home Therapy	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health Condition	
Dialysis	
Clinical Trial	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ○ **Yes** ○ **No**

Date: _____ Type of Surgery/Procedure: _____

Name/Phone Number of Physician performing surgery/procedure: _____

Hospital/Facility: _____

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4. Have you ever been admitted to the hospital or been in the emergency room in the past 6 months?

◯ **Yes** ◯ **No**

If Yes, please describe:

_____

_____

5. Other Needs:

_____

_____

_____

I hereby authorize the above provider to give the SHCA Transition Assistance Program any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that I am entitled to a copy of this authorization form. I also authorize SHCA to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

Home _____ Cell _____ Work _____

Do NOT leave confidential information on my voice mail _____

Signature of Patient if 18 or over:	Date:
Signature of Parent or Guardian if Patient is under 18:	Date: