



## Transitional Coverage Request Form Request For Continuity Of Care For Medical Benefits

Subscriber's Name: \_\_\_\_\_  
 ID # \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Daytime Telephone #: (\_\_\_\_) \_\_\_\_\_ Home Telephone #: (\_\_\_\_) \_\_\_\_\_  
 Policy Effective Date: \_\_\_\_\_  
 Other insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, Name of Insurance \_\_\_\_\_ Effective Date \_\_\_\_\_

**This request applies only to members that are currently in treatment for an unstable, severe or life-threatening condition that requires continuation of care with their current provider or for those who have entered their second trimester of pregnancy on or before their VNS CHOICE effective date. Please have your Provider complete the following:**

Form Completed By: \_\_\_\_\_ Title: \_\_\_\_\_  
 Name of Treating Provider: \_\_\_\_\_ Hospital Affiliation: \_\_\_\_\_  
 Primary Diagnosis: \_\_\_\_\_  
 Complications: \_\_\_\_\_  
 If pregnant, please give estimated due date: \_\_\_\_\_  
 Date started 2<sup>nd</sup> trimester \_\_\_\_\_ Date of Most Recent Visit: \_\_\_\_\_  
 Frequency of Visits: \_\_\_\_\_  
 Date of Most Recent Hospitalization (if applicable) \_\_\_\_\_ Name of Hospital \_\_\_\_\_  
 For the latest Hospitalization, please provide:  
 Primary Diagnosis  Copy of discharge summary  Copy of operative report  Copy of pathology report  
 Current Therapy: \_\_\_\_\_  
 Proposed Treatment Plan: \_\_\_\_\_ Duration Treatment: \_\_\_\_\_  
 I agree to accept VNS CHOICE reimbursement as payment in full. I also agree to comply with all of VNS CHOICE UM/QI policies and procedures.  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I understand that requests for continuity of care transition benefits are approved at the sole discretion of VNS CHOICE and the term of any such transition period will terminate when VNS CHOICE determines that care can be safely transferred to a network participating provider. I further understand that once the transition period has expired or my request is denied, the benefit for out-of-network services as stated in my subscriber contract will apply. I understand that any claim by me may be denied and/or coverage cancelled without written notice if I have provided materially false information in my request. My signature below authorizes the provider indicated to release medical records to VNS CHOICE Utilization Management Department in order to review this request. I have reviewed the information supplied on this form and attest to its accuracy to the best of my knowledge.**

To expedite this process, **please fax form to: 1-866-791-2214**

OR Mail Form to:  
 VNS CHOICE  
 Attention: UM Department  
 1250 Broadway, 3<sup>rd</sup> Fl.  
 New York, NY 10001

<b>For Office Use Only</b>  Approved <input type="checkbox"/> Denied <input type="checkbox"/>	Date: _____  Signature: _____
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**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_