Transition of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

Applies to:

Aetna® plans

All health benefits and health insurance plans offered, underwritten and/or administered by: Allina Health and Aetna Health Insurance Company (Allina Health)

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
- 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) or is part of your plan's highest benefit tier. The online provider search tool is found on the health plan's web page. 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** (Plan 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 on page 5**, including the diagnostic and treatment information requested on **page 6**.

Step 3: **Fax or send** the completed form to us for review. You can mail the completed form to the address listed on your ID card. You should complete one form for each health care provider.

Step 4: You can also submit a digital copy of the form by visiting your secure member website at **Aetna.com**. Once you log in, click **Support > Contact Us > Send a Message.** From the Message Center, click **New Message > Send Message.** From here, choose the message topic **"Other"** and load your completed form.

Email requests to MedicarePrecert@aetna.com or Fax medical requests to 860-900-7250

Fax mental health/substance use requests to 959-282-8799

Fax requests for injectable medications given in a medical setting (doctor's office or infusion center) to 1-844-268-7263

Be sure to complete all fields on pages 4, 5 and 6. *Your request will be answered faster that way.*

Transition of care coverage questions and answers

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

TOC coverage is temporary. Medicare does not require submission of this form. We automatically apply 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
  or
- Is not included in a Narrow Network, or a plan sponsor-specific network, and your benefits change to include one of these networks.

TOC coverage is only for the requested doctor. It does not include health care facilities, durable medical equipment (DME) vendors or pharmaceutical items. If we approve TOC coverage, the doctor must use a health care facility, DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?

A. An active course of treatment means you have begun a program of planned services 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, members who:

- Are pregnant and have begun a course of treatment (including prenatal care) for the pregnancy from the obstetrician (Ob) or facility.
- Are undergoing a course of treatment from the provider or facility for a serious and complex condition, such as chemotherapy or radiation therapy.
- Are determined to be terminally ill (have a medical prognosis that their life expectancy is 6 months or less) and are receiving treatment for such illness from such provider or facility.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance use. (Must have had at least one treatment session within 30 days before member or participating health care provider status changed.)
- Have an ongoing or disabling condition that suddenly gets worse.
- May need or have had an organ or bone marrow transplant.
- Are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

To be considered for TOC coverage, treatment must have started **before** the enrollment or re-enrollment date.

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

A. This includes health care professionals such as physical therapists, occupational therapists, speech therapists and agencies that provide skilled home care services, such as visiting nurses. TOC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks. TOC does not apply to other health care facilities (for example, skilled nursing facility), DME vendors or pharmaceutical items.

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

A. To be approved for TOC, the procedure or service must be a covered benefit under the terms of your plan.

Transition of care coverage questions and answers

Q. How long does TOC coverage last?

A. Usually, TOC coverage lasts 90 days, but this may vary based on your condition (for example, pregnancy). We will tell you if your TOC coverage request is approved and how long the coverage will last.

Q. Does TOC coverage apply if my plan does not have a provider network?

A. No.

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 or behavioral health number.

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

A. We will make a decision after we receive your request. We will then send you a letter via U.S. mail. The letter will say whether or not you are approved.

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☐ **Medical** ☐ **Mental health/substance use**

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

Who is submitting the request? ☐ Member ☐ Provider

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

Plan name (please print)	Plan number(s)	Plan effective date

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)*	Phone number
Patient's address (please print)	Plan type/product	
	Phone number for subscriber or patient submitting request (Business hours, 9 AM–5 PM)	

3. Authorization

I request approval for coverage of ongoing care from the health care 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 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 age 17 or older**)	Date *(MM/DD/YYYY)*
Parent's signature (**required if patient is age 16 or younger**)	Date *(MM/DD/YYYY)*

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4. Provider information (Note: Provide all specific information to avoid delay in the processing of this request.)

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

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's network for any referrals, lab work or hospitalizations for services not part of the requested treatment. The provider completing the form may not be leaving the network but may request continuing care to be provided by a hospital that is leaving the network.

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Patient's name (please print)	Birthdate *(MM/DD/YYYY)*

Provider: Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY REQUEST

Are you in a current course of active treatment (reconstruction surgery, radiation therapy, immunotherapy, targeted agents **OR** chemotherapy) for cancer with treatment initiated in the last 90 days?

☐ Yes ☐ No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next visit dates: (MM/DD/YYYY): _____

Diagnostic and CPT/HCPCS codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for antibiotics, **OR** hyperalimentation/total parenteral nutrition?

☐ Yes ☐ No Treatment start date: (MM/DD/YYYY): _____ Expected end date: (MM/DD/YYYY): _____

Diagnostic and CPT/HCPCS codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a surgeon's office and is the member within the 90 days post-operative period **OR** has the member started a series of surgical procedures to correct the same condition?

☐ Yes ☐ No Date of surgery: (MM/DD/YYYY): _____

Diagnostic and CPT/HCPCS codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed their first visit with an obstetrician (Ob) office?

☐ Yes ☐ No First Ob visit: (MM/DD/YYYY): _____ Expected date of delivery: (MM/DD/YYYY): _____

Diagnostic and CPT/HCPCS codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment start date: (MM/DD/YYYY): _____ Last date of treatment: (MM/DD/YYYY): _____

Diagnostic and CPT/HCPCS codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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.* **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Misrepresentation

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Patient/Member Signature:	**Date:**

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Participating health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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