

Transition of Care Coverage Request

Personal and Confidential



This form represents a formal request for coverage of services from a **nonparticipating** treating physician or to cover Durable Medical Equipment (DME) from a **nonparticipating** DME vendor for a specific period of time. You will receive a coverage determination by mail. If you are enrolled in a Group Health Cooperative or Group Health Options Inc. health plan and coverage is not approved, then care by the nonparticipating provider will not be covered after the new plan's effective date. If you are enrolled in a Group Health Options plan that provides an out-of-network benefit (Options, Alliant Plus) and coverage is not approved because the provider is nonparticipating, the services may be covered at the out-of-network benefit level.

This form must be submitted to a Group Health Clinical Review Unit:

If your home address is in:	Send to:	Or fax to:
Eastern Washington or Idaho	Clinical and Quality Review Unit P.O. Box 204 Spokane, WA 99210-0204	509-742-3574
Western Washington	Clinical and Quality Review Unit 12400 East Marginal Way Mailstop: AMB-2/CRU Seattle, WA 98168-2559	206-901-6108

Employee instructions

1. Please complete sections 1 through 4.
2. Please print in black or blue ink.
3. Sign and date Section 4. If the patient is age 17 or older, he or she must also sign and date Section 4.
4. Give the form to the patient's nonparticipating treating physician, who will complete Section 5 and send the completed form to Group Health.

1. Employer information

Employer name	Plan effective date (required)
---------------	--------------------------------

2. Health plan information

Please check the box next to the health plan you are a member of:

Group Health Cooperative

Group Health Options, Inc.:

Options Options Select Alliant Plus Alliant Select

3. Patient information

Employee name	Social Security number
---------------	------------------------

Employee address

Patient name	Birthdate (MM/DD/YY)	Telephone number ()
--------------	----------------------	-------------------------

Name of nonparticipating treating physician or DME vendor	Telephone number ()
---	-------------------------

4. Authorization

I am requesting coverage for continuing care or DME by the provider named above for a condition for which treatment began prior to the plan effective date or prior to termination of the provider from the plan's provider network. If approved, I understand that the coverage for continuing care or equipment rental specified below will be covered for a limited period. Further, I authorize the physician or DME provider named above to provide medical information or records to the plan as required to make a coverage determination.

Patient's signature (required if patient is 17 or older)	Date
--	------

Parent's signature (required if patient is 16 or younger)	Date
---	------

5. Physician information

The above named patient is a member of a plan offered by Group Health Cooperative or Group Health Options, Inc. or will become a member as of the plan effective date. Although you are not, or soon will not be, a participating provider in the plan network, the patient has requested that we cover care provided by you for a specified period of time because of a condition requiring an active course of treatment, or a pregnancy that began prior to the plan effective date or effective date of termination from the network. An active course of treatment is defined as a planned program of services rendered by a physician or DME provider starting on the date a physician first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment. So that we can evaluate your patient's request, please list the patient's diagnosis below. List all treatment for the condition and the dates rendered, attaching additional sheets if necessary. Also attach a brief statement of the patient's current condition and treatment plan, together with appropriate medical records. For pregnancies, please enter the patient's Estimated Date of Conception (EDC). In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.

Diagnosis	Treatment	Treatment date(s)
-----------	-----------	-------------------

Name of nonparticipating treating physician or DME vendor	Telephone number ()
---	-------------------------

Address of nonparticipating treating physician or DME vendor
--

Signature of nonparticipating physician or DME vendor contact	Date
---	------

Warning: A carrier may deny plan benefits if false information materially related to claim was provided by the applicant.