



## TRANSITION OF CARE REQUEST

Collect **ALL** the following information for members who request continuing care with a non-participating (non-par) provider. This would include pregnant members, members with very serious conditions, members scheduled for a procedure, etc.

Date of Request: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

Member's Name \_\_\_\_\_ ID# \_\_\_\_\_

Member's home telephone number: \_\_\_\_\_

Diagnosis or condition: \_\_\_\_\_

*If pregnant, what is the expected due date:* \_\_\_\_\_

*If cancer, is the member still receiving chemo &/or radiation therapy?*  
\_\_\_\_\_

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*When will the chemo/radiation treatments end?* \_\_\_\_\_

*If treatments completed, how often do they see the MD for follow-up?* \_\_\_\_\_

*If other chronic illness, how often do they see the non-par MD?* \_\_\_\_\_

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Non-par physician currently providing care: \_\_\_\_\_

Non-par physician's phone # &/or location: \_\_\_\_\_

Additional comments: \_\_\_\_\_

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### For office use only

Transition of care decision: \_\_\_\_\_ Medical Director signature: \_\_\_\_\_

Date(s) member notified (telephone & letter): \_\_\_\_\_

Authorization# \_\_\_\_\_ CareStepp entry date: \_\_\_\_\_

Document in CareStepp the date notified & what member was told. Attach copy of letter.