Transition of Care/ Continuity of Care Information

TRANSITION OF CARE

Gives new members the option to request extended coverage from their current health care professional who will be out of network with the new plan. This is for limited time due to a specific medical condition, and may continue until the safe transfer to a network health care professional can be arranged.The provider must agree to accept network rates. Examples of qualifying medical conditions can be found below. You must apply for transition of care no later than 30 days after the date your coverage begins using the application.

CONTINUITY OF CARE

Gives existing members the option to request to extended care from their current health care professional if he or she is, or is soon to be out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time. Examples of covered medical conditions can be found below. You must apply for continuity of care using the enclosed application.

HOW TRANSITION OF CARE/CONTINUITY OF CARE WORKS

You are eligible for a Transition of Care/Continuity of Care only when you have a significant medical condition that requires you to continue care with a specific provider as determined in each individual situation.

If your request is approved for the medical condition(s) listed in your application(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for a defined time frame, as determined by us. All other services or supplies must be provided by a network health care professional for you to receive in-network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the timeframe approved by us, you must follow your plan's out-of-network requirements.

Depending on the actual request, a medical necessity determination and a notification or prior authorization may still be required in order for a service to be covered.

Examples of medical conditions that may qualify you for Transition of Care/Continuity of Care includes, but is not limited to:

- ✓ Pregnancy in the second or third trimester through six weeks post-delivery.
- ✓ Transition of Care for the mother does not apply to the newborn. If the care provider or facility is out-of-network for the newborn, please submit a network gap request for services for the newborn by calling the number on your member ID card.
- ✓ Ongoing treatment for a life threatening condition.
- ✓ Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- ✓ Ongoing treatment after a completed complex surgery or are in the middle of a staged surgery.
- ✓ Treatment for end-stage kidney disease and are on dialysis.
- ✓ Ongoing care after a recent organ transplant, or you are on the waiting list for a transplant with a specific physician.
- ✓ Ongoing treatment for acute significant psychiatric problems or other significant behavioral health services.
- ✓ Ongoing treatment for a rare and complex medical condition requiring continuity with a specific specialist.

Examples of conditions that do not qualify includes:

- × Routine exams and pediatric care; care of chronic conditions like as diabetes, arthritis, allergies, asthma, kidney disease and hypertension; elective surgeries and procedures.

WHAT DO I DO NEXT?
Please fill out the enclosed form and do one of the following:

Please fill out the enclosed form and fax to **516.723.7392**

Or mail to:
BRIGHTON HEALTH PLAN SOLUTIONS
P.O. BOX 8030,
GARDEN CITY, NY 11530

Transition of Care is a service which enables new enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Continuation of Care is a service which enables Brighton Health Plan Solutions existing enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

TRANSITION OR CONTINUITY OF CARE BENEFITS APPLICATION FORM

Complete section 1 to determine if you are eligible for transition or continuity of care benefits

- If you answer YES to at least one question, you may be eligible for Transition or Continuity of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition or Continuity of Care benefits.
- To locate a new physician in your Benefit Plan network, please visit us online at www.magnacare.com, or www.mycreatehealth.com and click on “Find a Healthcare Provider”.

Complete SECTION 2 if you answered YES to at least one of the questions in SECTION 1.

- Proceed to SECTION 2 only if you answered YES to at least 1 question in SECTION 1.
- Be sure to sign the authorization form to release your medical records.

SECTION 3 needs to be completed by your physician OR healthcare provider treating your condition

- If you are receiving care from more than one provider, you must complete this form for each provider.

Finally, mail or fax the completed application along with relevant medical records to the address or number noted at the bottom of the application.

- You must submit this form no longer than 30 days after your new MagnaCare or *Create* plan coverage begins. If you submit this application after the 30th day of your new coverage effective date, you will not be eligible for the Transition of Care.
- Eligibility also depends upon qualifying events listed in SECTION 1

SECTION 1: TO BE COMPLETED BY APPLICANT

Select the type of care you are seeking coverage for:

☐ Transition of Care (new member) ☐ Continuation of Care (existing member)

Question		
Are you in your 2nd or 3rd trimester of pregnancy?	☐ YES	☐ NO
Are you undergoing treatment for a life threatening condition?	☐ YES	☐ NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	☐ YES	☐ NO
Are you undergoing treatment after a completed complex or staged surgery?	☐ YES	☐ NO
Are you undergoing treatment for end-stage kidney disease and are on dialysis?	☐ YES	☐ NO
Did you recently receive a transplant, or are you on the waiting list for a transplant with a specific physician?	☐ YES	☐ NO
Are you undergoing treatment for significant acute psychiatric or behavioral health services?	☐ YES	☐ NO
Are you undergoing treatment for a rare and complex medical condition requiring continuity with a specialist?	☐ YES	☐ NO

SECTION 2: TO BE COMPLETED BY APPLICANT	
Employee Name	ID Number
Address	Home Phone
City, State, Zip	Work Phone
Employer Name	New Plan Effective Date
Patient Name	Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)	
Are you currently covered by other insurance: ☐ Medicare ☐ Medicaid ☐ Other ______________________	TOC Provider Information: ☐ Physician ☐ Facility ☐ Other Name: Specialty (e.g. Heme-onc; Ob/Gyn, Hospital etc.)

Authorization to release records:

I authorize all health care professionals or institutions to provide information concerning medical care, advice, treatment, or supplies for the patient named above.

______________________	______________	
Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor	**Date**	(OVER)

SECTION 3 TO BE COMPLETED BY THE HEALTHCARE PROVIDER

(One form needs to be completed by each provider or facility that is agreeing to the condition of Transition or Continuation of Care)

Please fill out and check the entire form for completeness and submit all 3 sections with any relevant medical notes to Brighton Health Plan Solutions at the address listed below.

<table>
<tr><th colspan="4">SECTION 3:
TO BE COMPLETED BY HEALTHCARE PROVIDER OR FACILITY CURRENTLY TREATING CONDITION</th></tr>
<tr><td colspan="2">Physician / Provider Name</td><td>Provider TIN Number</td><td>Provider Contact Phone Number</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">City, State, Zip</td></tr>
<tr><td colspan="2">Date of Last Visit</td><td>Next Scheduled Appointment</td><td>Frequency of Visits</td></tr>
<tr><td>Diagnosis Code</td><td>CPT Code</td><td colspan="2">Expected Length of Treatment, or if maternity, expected date of delivery</td></tr>
<tr><td colspan="2">E-mail address:</td><td colspan="2">Is treatment for an exacerbation of a previous injury or chronic condition?
☐ YES ☐ NO</td></tr>
<tr><td colspan="4">Treatment Plan & Explanation why transition/continuation of care with the current provider/facility is medically necessary. Please list services/CPT you are planning to provide.</td></tr>
<tr><td colspan="4">The above-named patient is a member of MagnaCare or Create. We understand you are not, or soon will not be a participating provider in the network. This member has asked that for this episode of care, for a defined period of time, we treat claims from you for as in-network under the member's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. By this form, you agree to accept rules and fee schedules that apply to participating providers for this episode of care. Payment under this agreement, together with any copayment, deductible or coinsurance for which the member is responsible under the plan is payment in full for the covered service. You will not seek to recover additional payment from the member or us in excess of payment in full, regardless of whether such amount is less than your billed or customary charge. If applicable, you will make referrals for services including laboratory services, to network providers which can be found at www.magnacare.com or www.mycreatehealth.com.</td></tr>
<tr><td colspan="2">Signature of Physician/Facility</td><td colspan="2">Date</td></tr>
</table>

Please fill out the enclosed form and fax to **516.723.7392**

Or mail to:
BRIGHTON HEALTH PLAN SOLUTIONS TOC,
P.O. BOX 8030,
GARDEN CITY, NY 11530

CONFIDENTIALITY NOTICE: The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.