Providence
Medicare Advantage Plans
P.O. Box 4327
Portland, OR 97208-4327
ProvidenceHealthAssurance.com

Providence Transition of Care Request

We are happy that you have chosen us as your health plan. Please complete the steps below to submit your Transition of Care Request.

Transition of Care Description:

- Considerations for:
  - New members
  - Member with change in plan or providers
- Begins on first day of new coverage

Consideration of Transition of Care Request:

- Reviewed case by case
- Decisions are based on medical necessity and not a guarantee of payment for services
- Payment is based on eligibility and benefits at time of service

When to Use Transition of Care:

- You are a new member to Providence
- You are a current member with a change to your insurance plan
- You need assistance to transition your providers under your new insurance plan

Checklist of Documents Needed to Review Your Transition of Care Request:

☐ Transition of Care Questionnaire Form (completed by member)
☐ Consent for Release of Information Form (completed by member)

Return the documents to:

- Mail – 3601 SW Murray Blvd., Beaverton, OR 97005, Attn: Care Management
- Email – Care.Management@Providence.org
- Fax – (503) 574-8171

Helpful Links and Phone Numbers:

- https://www.providencehealthplan.com/medicare - Providence Website
- phapd.providence.org/medicare/ - Find a Provider
- https://myprovidence.healthtrioconnect.com/ - MyProvidence
- Providence Care Management: (503) 574-7247 or 800-662-1121 (TTY: 711)
  Monday – Friday, 8:00 am - 5:00 pm (Pacific Time)
- Providence Customer Service: (503) 574-7500 or 800-562-8964 (TTY: 711)
  Seven days a week, 8:00 am – 8:00 pm (Pacific Time)

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Providence Transition of Care Questionnaire

Please complete the questionnaire for the individual with the care transition needs

Member Name: _____Date of Birth: _____
Phone Number: _____ Address: _____
Member ID # (if known): _____ Policy Holder Name (if dependent): _____

1. What type of coverage do you have?

☐ Medicaid ☐ Medicare
☐ Individual Plan
☐ Through Employer (specify employer):
_____

2. Are you a new or current member?

☐ New ☐ Current

3. If current, have you had a benefit change to your coverage?

☐ Yes ☐ No ☐ Unknown

4. Do you need assistance establishing care with any new providers?

☐ Yes ☐ No ☐ Unknown

5. Are any of your current providers not contracted with Providence?

☐ Yes ☐ No ☐ Unknown

6. Do you have treatment scheduled prior to coming on plan?

☐ Yes ☐ No

If yes, list the procedure, date, facility, provider and provider phone number: _____
_____
_____
_____
_____
_____
_____

7. Do you need assistance with any of the following?

☐ Behavioral Health ☐ Chemo/Radiation
☐ Substance Use ☐ Transplant
☐ Pregnancy ☐ Medical Equipment
☐ Other: _____ ☐ Medication
_____

8. List provider, specialty and phone number for each condition currently being treated, current medication(s) and the type of equipment and vendor for DME supplies:

_____
_____
_____
_____
_____

9. Tell us more about your situation: _____
_____
_____
_____
_____
_____
_____
_____

Please return the completed Transition of Care Questionnaire and Consent Form to Care Management in one of the following ways:

Mail: 3601 SW Murray Blvd.
Beaverton, OR 97005
Attn: Care Management
Email: Care.Management@Providence.org
Fax: (503) 574-8171

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Authorization To Use/Disclose Protected Health Information

RELEASE BY A HEALTHCARE PROVIDER TO PROVIDENCE MEDICARE ADVANTAGE PLANS

THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID

I authorize my healthcare provider: _____
Healthcare Provider's full name (e.g., Dr. Jane C. Doe, MD)

_____
Street Address/City/State/Zip

to disclose a copy of the specific health information described below regarding:

Name of Individual: _____ **Date of Birth:** _____
First Name, Middle Initial, Last Name (MM/DD/YYYY)

to **Providence Medicare Advantage Plans** for the purpose of coordinating the transition of my care to Providence Medicare Advantage Plans.The specific health information to be used/disclosed consists of (*Describe condition(s), treatment(s), dates of service, etc.)*

_____
_____
_____
_____
_____
_____

_____My protected health information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

(Initial all that apply):

___ Alcohol/Drug/Substance Abuse
___ Genetic testing
___ HIV or AIDS
___ Mental health

I have read the contents of this authorization. I understand, agree, and allow my provider to the use and release of my information as I have stated above. I also understand that signing this authorization form is of my own free will. I understand that Providence Medicare Advantage Plans does not require that I sign this authorization form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits. **I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization. Any uses or disclosures already made with my Authorization cannot be taken back.**

To revoke this Authorization, please send a written statement to Providence Medicare Advantage Plans at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization shall be in force and effect until the following Please check the below expiration date you wish to have for this authorization:

☐ Maximum allowed time of 24 months from the date of signature

☐ Other Date/Event listed here: (Only If less than 24 months)

_____

By:_____
Date:_____
(Individual)

- OR -

By:_____
Date:_____
(Individual's representative)
Relationship to member:☐Parent ☐Legal guardian* ☐Holder of Power of Attorney*

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Please keep a copy for your records