Providence
Medicare Advantage Plans

Care Management

Transition of Care: Member Forms

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Transition of care support

Providence Care Management assists members, member representatives, and practitioners during the transition from one health plan to another, change in benefit plan or upon termination of a practitioner's relationship with Providence; each is reviewed on a case-by-case basis. Care Management's Transition of Care questionnaire and release of information are designed to alert our team to needs a member may have during their transition.

Support when needed

Not all members need Care Management Transition of Care support, but it may be helpful when:

- You are a current member with a change to your coverage.
- You are a new member and your current physical health or behavioral health provider is out of network and you do not have out of network benefits.
- You are a new member and have an upcoming pre-approved procedure, treatment, and/or pregnancy.
- You are a new member and need help with referrals and/or prior authorization for needed care.

How Care Management can help

Care Management helps members with clinical and non-clinical needs by:

- Providing education about plan services and processes.
- Assistance finding and establishing with new physical health or behavioral health providers.
- Navigation to Pharmacy, Durable Medical equipment, Diabetic supplies, or other services or resources.
- Care Coordination.
- Any other health care navigation support needed during this transition.

Helpful contact information and resources

- Providence Website: **https://www.providencehealthplan.com/**
- Find a Provider (Provider Directory): **https://phppd.providence.org/**
- MyProvidence: **https://myprovidence.healthtrioconnect.com/**
- Providence Care Management: Monday – Friday, 8:00 am – 5:00 pm (PST): (503) 574-7247 or 800-662-1121 (TTY: 711)
- Providence Customer Service: 8 a.m. to 8 p.m. (Pacific Time) 7 days a week, October 1st through March 31st and Monday - Friday, April 1st through September 30th. (503) 574-8000 or 800-603-2340 (TTY:711)
- **For a list of frequently asked questions, go to our website: https://ProvidenceHealthAssurance.com/transitionofcare**

Note: Submitting a transition of care packet is not required. Members can choose to see providers at out of network rates if they have out of network benefits. Submitting a transition of care packet does not guarantee in-network rates. If a benefit exception request is submitted and in-network rates are approved, members may still be liable for any balance billing by the out of network provider. Decisions are based on medical necessity and not a guarantee of payment for services. Payment is based on eligibility and benefits at the time of service.

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Providence Transition of Care Questionnaire

Checklist of documents needed to review your Transition of Care Request:

☐ Transition of Care Questionnaire Form (below or available online – see link above)

☐ Consent for Release of Information Form – This gives Care Management permission to outreach to your providers to help coordinate your care.

Complete these documents and send to us in any of the following ways:

- Mail: 4400 NE Halsey Street, Bldg. #2 Portland, OR 97213 Attn: Care Management Transition of Care
- Email: Care.Management@Providence.org
- Fax: 503 -574-8171

Member Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Member ID # (if known):** _____

Policy Holder Name (if dependent): _____

Group ID (if known): _____ **Group Name (if known):** _____

Does your new plan have out of network benefits?

☐ Yes
☐ No
☐ Unknown

What type of coverage do you have?

☐ Unknown
☐ Dual Special Needs Plan (DSNP)
☐ Medicare

Do you need assistance establishing care with any new providers?

☐ Yes
☐ No
☐ Unknown

Are any of your current providers not contracted with Providence?

☐ Yes
☐ No
☐ Unknown

If you are currently a Providence member, have you lost a benefit and need assistance?

☐ Yes
☐ No
☐ Unknown
☐ N/A, new member

Do you have any upcoming treatments, procedures, or surgeries that were scheduled to occur after your Providence coverage starts?

☐ Yes
☐ No

What brings you to Providence Health Plan?

Do you need assistance with the following?

- ☐ Primary Care Provider
- ☐ Specialist(s)
- ☐ Behavioral Health and/or Physical Health
- ☐ Procedures/Surgeries
- ☐ Transplant
- ☐ Pregnancy
- ☐ Cancer
- ☐ Diagnostic Imaging
- ☐ Home Care Services
- ☐ Outpatient Therapy
- ☐ Medical Equipment/Supplies
- ☐ Medications
- ☐ Specialty Medications
- ☐ Other

Please list any other assistance needed:

If you indicated needing assistance with any of the above, please list provider names, surgery/procedure dates, and any other details regarding support needed:

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Authorization To Disclose
Protected Health Information
For Transition of Care

Use this form to authorize your current healthcare provider to disclose your health information to Providence Medicare Advantage Plans and your new provider, for the purpose of coordinating the transition of your care to Providence Medicare Advantage Plans. It is crucial to note that Providence Medicare Advantage Plans seeks this authorization urgently, deviating from HIPAA's standard 30-day timeframe to expedite and facilitate the timely coordination of healthcare.

I authorize my current healthcare provider:_____
Current 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 Patient:_____ Date of Birth:_____
First Name, Middle Initial, Last Name (MM/DD/YYYY)

The specific health information to be used/disclosed consists of records related to my condition (*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):

_____AIDS or HIV	_____Maternity/Pregnancy (Reproductive Health)
_____Alcohol/Drug/Substance Abuse (Diagnosis, treatment, or referral information) *	_____Mental Health Data and Records
_____Genetic Information (services or tests)	_____Sexually transmitted illness/disease (testing and treatment)

I authorize Providence Medicare Advantage Plans to forward the records listed above to my new provider:

_____

New Provider's full name (e.g., Dr. Jane C. Doe, MD)

_____

Street Address City/State/Zip

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 12 months from the date of signature
- ☐ Other Date/Event listed here: (Only If less than 12 months) _____

By:_____ **Date:**_____
(Individual)

- OR -

By:_____ **Date:**_____
(Individual's representative)

Relationship to member: ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney**

PLEASE KEEP A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS
Complete this document and send to us in any of the following ways:

Mail:
4400 NE Halsey Street, Bldg. #2
Portland, OR 97213
Attention: Care Management Transition of Care

Email: Care.Management@Providence.org

Fax: 503-574-8171