Zing HEALTH

Transition of Care/Continuity of Care Request Form

GENERAL INFORMATION ABOUT TRANSITION OF CARE ASSISTANCE

What is Transition of Care? Transition of Care coverage allows you to continue to receive services once enrolled in Zing Health for specified medical and behavioral conditions for a defined period of time with health care professionals who do not participate in the Zing Health network until safe transfer of care to a network doctor or facility can be arranged**.** You must apply for Transition of Care at enrollment, or at the time of a Zing Health provider network change, but no later than 30 days after the effective date of your coverage.

What is Continuity of Care? Continuity of Care allows you to receive services at in-network coverage levels for specified medical and behavioral conditions for a defined period of time. Continuity of Care occurs when there are changes to your Zing Health network, and there are clinical reasons preventing immediate transfer of care to an in-network doctor. A request must be submitted to Zing Health within 30 days of the network change.

How Transition of Care/Continuity of Care Works:

- You must already be under treatment for the condition identified on the Transition of Care/ Continuity of Care request form.
- If Transition of Care/Continuity of Care is approved for medical or behavioral conditions, you will receive the in-network level of coverage for treatment of the specific condition by the health care professional for a defined time frame, as determined by Zing Health. If your plan includes out-of-network coverage and you choose to continue care out of network beyond the time frame approved by Zing Health, you must follow your plan's out-of-network provisions. This includes any pre-authorization requirements and any cost sharing and/or balance billing that may occur from the out-of-network provider.
- If approved, Transition of Care/Continuity of Care coverage applies only to treatment of the medical or behavioral condition specified and with the health care professional identified on the request form. All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage levels.
- The availability of Transition of Care/ Continuity of Care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-authorization may still be required for a service to be covered.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period (generally six to eight weeks).
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions, etc. For the purpose of this policy, "active treatment" is defined as a doctor visit or hospitalization with documented changes in a therapeutic regimen within 21 days prior to your plan effective date or your health care professional's termination date.
- Hospital confinement on the plan effective date.
- Behavioral health conditions during active treatment.
- Routine Pregnancy in the second or third trimester at the time of the effective date of coverage or time of health care professional termination.
- High-risk pregnancy at the time of the effective date of coverage or time of health care professional termination. This is defined as:
    - early delivery (three weeks prior to due date) in previous pregnancy
    - o patient has had/has gestational diabetes
    - o pregnancy induced hypertension
    - multiple inpatient admissions during this pregnancy
    - mother's age is > 35 years old.

What time frame is allowed for transitioning to a new participating health care professional?

If Zing Health determines that transitioning to a participating health care professional is not recommended or safe for the conditions that qualify, services by the approved non-participating health care professional will be authorized for a specified period of time or until care has been completed or transitioned to a participating health care professional, generally not to exceed 90 days unless otherwise authorized for an additional period of time.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, or one requiring a special course of treatment, you should select an in-network doctor to meet your ongoing health care needs. You do not need to complete this form if you are selecting an in-network doctor. If you need assistance selecting a new doctor, you should contact our Customer Service Department at 1-866-946-4458.

If one or more of the above situations apply to you and you would like to see if you are eligible to participate in transition of care, please:

- Call the Customer Service number on the back of your ID card, and they will assist you with understanding how you should complete your form. Customer Service will assist you in locating a network doctor. The determination of whether you qualify for a transition or continuation of care will be made by the Zing Health Services Department.
- Or, fax this completed request form to Zing Health Services Department at 1-844-946-4458.
- Or, mail to Zing Health, Attention: Prior Authorization, 225 W. Washington Street Suite 450, Chicago, IL 60606

To help ensure that your care is not interrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care and your current provider is not part of our network. If your doctor is not part of our network and you need assistance locating a network doctor, contact Customer Service and they will assist you with a network provider.

Transition of Care/Continuity of Care Request Form

❑ Transition of Care – New enrollee

❑ Continuity of Care – Existing member whose provider network has changed

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Patient's Name	ID#	Effective Date of Enrollment with ZIng Health (mm/dd/yyyy)	
Patient's Birth Date (mm/dd/yyyy)	Relationship to Patient ❑ Spouse ❑ Representative ❑ Self	Work Phone	Home Phone/Cell
Home Address Street	City State ZIP		Email Address

1. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
2. Is the patient scheduled for surgery or hospitalization after your effective date with Zing Health ❑ Yes ❑ No
3. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
4. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes No
5. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
6. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
7. Is the patient receiving mental health and/or substance abuse treatment? ❑ Yes ❑ No
8. Is the patient pregnant and in the second or third trimester of pregnancy? ❑ Yes ❑ No
   a. Due date_____(mm/dd/yyyy)
9. If yes, is the pregnancy considered high risk (e.g. multiple births, gestational diabetes)? ❑ Yes No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests transition of care/continuity of care.

_____

_____

_____

_____

_____

_____

11. Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name		Health Care Professional Phone #
Health Care Professional Specialty		
Health Care Professional Address		
Hospital Where Health Care Professional Practices		Hospital Phone #
Hospital Address		
Reason Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

12. Is this patient expected to be in the hospital when coverage with Zing Health begins or during the next 90 days? ❑ Yes ❑ No

13. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care Coverage. If these care needs are not associated with the condition for which you are applying for Transition of Care/ Continuity of Care coverage, you need to complete a separate Transition of Care/Continuity of Care Form.

_____

_____

_____

I hereby authorize the above provider to give Zing Health any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care Benefits under a Zing Health Benefit Plan. I understand that I am entitled to a copy of this authorization form. I also authorize Zing Health to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply: ❑ Home ❑ Cell ❑ Email ❑ Do not leave confidential information on my voice mail	
Signature of Patient	Date (mm/dd/yyyy)