Transition of Care Request Form

Transition of Care allows you to receive support from our specially trained Registered Nurses and Plan Specialists to ensure a smooth transition to your new Health Plan. Complete the Transition of Care Request Form and Medical Waiver if you are currently undergoing treatment, have a scheduled procedure within the first 30 days of your new plan effective date, or have a complex medical condition. Transition of Care only applies to the specific conditions outlined on this form. Submit this completed form and Medical Waiver to toc@imagine360.com.

For assistance in finding a provider or questions about your benefits, please contact your health plan at the phone number on your benefits ID card or email myplan@imagine360.com.

Employer	Policy #	Employee Date of Enrollment (mm/dd/yyyy)	
Employee Name		Employee ID	
Home Address	City, State	Zip	
Patient's Name	Patient's SSN	Patient's DOB (mm/dd/yyyy)	Relationship to Employee
Patient's Phone	Patient's Email		Best Time to Call

1. Is the patient currently receiving treatment for a condition? ☐ YES ☐ NO Date of Service: ___________ (mm/dd/yyyy)
2. Is the patient currently scheduled for surgery or hospitalization? ☐ YES ☐ NO Date of Admission/Surgery: ___________ (mm/dd/yyyy)
3. Is the patient undergoing treatment for chemotherapy, radiation therapy, cancer therapy or terminal care? ☐ YES ☐ NO Date of Service: ___________ (mm/dd/yyyy)
4. Does this patient's provider prescribe a specialty medication that is self-injectable, physician administered? ☐ YES ☐ NO Date of Service: ___________ (mm/dd/yyyy)
5. Does this patient's provider prescribe an IV or infusion that is administered in an infusion center, physician's office or in the patient's home? ☐ YES ☐ NO Date of Service: ___________ (mm/dd/yyyy)
6. Is the patient receiving dialysis treatment? ☐ YES ☐ NO Date of Service: ___________ (mm/dd/yyyy)
7. Is the patient undergoing transplant evaluation or has previously received a transplant? ☐ YES ☐ NO Date of Transplant: ___________ (mm/dd/yyyy)
8. Is the patient pregnant? ☐ YES ☐ NO Due date: ___________ (mm/dd/yyyy)
9. If you did not answer yes to any of the above questions, please describe the patient's condition for which patient may require Transition of Care:
____
____
10. List current prescribed and over the counter medications:
____

Please complete the information below pertaining to your care providers:

Provider's Name	Provider's Phone #
Provider's Specialty	Reason/Diagnosis
Provider's Address	Next Date of Service

Provider's Name	Provider's Phone #
Provider's Specialty	Reason/Diagnosis
Provider's Address	Next Date of Service

Provider's Name	Provider's Phone #
Provider's Specialty	Reason/Diagnosis
Provider's Address	Next Date of Service

Facility for Upcoming Services	Facility Phone #
Facility Address	
Reason/Diagnosis	
Date(s) of Admission/Surgery (mm/dd/yyyy)	Type of Surgery (if applicable)
Treatment being received and expected duration	

Please submit this request form to: toc@imagine360.com
Contact your health plan at using the number on your ID card or call 800-716-2852 if you have any questions regarding the Transition of Care request.

Medical Release Form

Employer		Policy #	Date (mm/dd/yyyy)	
Employee Name			Employee ID	
Home Address		City, State	Zip	
Patient's Name	Patient's SSN		Patient's DOB (mm/dd/yyyy)	Relationship to Employee
Patient's Phone	Patient's Email			Best Time to Call
Emergency Contact Name	Emergency Contact Phone Number			Relationship to Patient

Your Health Plan's Medical Management team will need information regarding your medical history in order to effectively assist you in your coordination of care.

Medical Release

I hereby give my authorization for the release both verbally and in writing, of my medical records, to include treatment diagnoses, diagnostic records, laboratory results, and other information in my health record to the Health Plan's Medical Management team. I understand that the Health Plan's Medical Management team will use these records to assess program needs as it relates to my health and I understand that the Health Plan's Medical Management team may send these records to physicians or other Health Care providers for review as it relates to the notification or case management process.

By signing this release, I consent to enrollment in the Medical Management program.

Signature of Patient/Guardian: ___________________________________Date: _____________

This release is in effect for one year following the date of your signature and applies to all current treating physicians and specialists (medical and/or mental) and family members as listed: ____

Please submit this request form to: toc@imagine360.com

With respect to the HIPAA Privacy Rule, a permissible use or disclosure of Protected Health Information is for Treatment, Payment, or Healthcare Operations per section 164.502(a)(1)(ii). This request is being made by the health plan and its Business Associate for determining eligibility and coverage under the plan, reviewing heath care services for medical necessity, coverage, justification of charges, and the like; and utilization review activities which are defined as Payment per section 164.501 of the Privacy Rule.