Kelsey Seybold Clinic®

Transition Coverage Request

This form represents a formal request to Kelsey-Seybold to cover continuing care from an **Out-of-Network** Treating Physician for a specified time period. **Please complete all items to expedite your request.** You will receive a coverage determination by mail. If the coverage is not approved, care by the Out-of-Network Provider after the plan's effective date will not be covered. A separate Transition Coverage Request Form must be completed for each condition for which you or your covered dependents(s) are seeking transition of care benefits. When the form asks for the patient's name, utilize the name of the person who is actually undergoing care. The completed form must be signed and dated by the patient for whom transition of care benefits are being requested. If the patient is a minor, a parent or guardian's signature is necessary. **The completed form should be marked "Confidential" and submitted to the following address: Kelsey-Seybold Clinic, Utilization Management Department, Attn: Transition of Care Unit, 11511 Shadow Creek Pkwy, Pearland, TX 77584 or via fax 713-442-5333.**

Employer's Name (Please print)		
Employee's Name (Please print)	Employee's Date of Birth	Work Phone
Home Address Street City State Zip		Home Phone
Patient's Name (Please print)	Patient's Relationship to Employee Spouse Dependent Self	

1. Are you or any of your covered dependents pregnant and in the second or third trimester of pregnancy? Yes No
2. If yes, when is the due date? _____/_____/_____.
3. Are you or any of your covered dependents currently in the hospital? Yes No
4. Are you or any of your covered dependents scheduled for a procedure, surgery or hospitalization after your effective date with the new health care plan? Yes No
5. Are you or any of your covered dependents involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate an Organ Transplant? Yes No
6. Are you or any of your covered dependents receiving treatment as a result of a recent major/minor surgery? Yes No
7. Are you or any of your covered dependents in the process of a staged surgery such as a cleft palate repair? Yes No

If you answered "Yes" to any of the above questions, please complete the applicable information below.

Name of Out-of-Network Treating Provider (Please print)		Provider Telephone Number
Address of Out-of-Network Treating Provider (Please print)		
Name of Hospital at which Provider practices		Hospital Telephone Number
Address of Hospital (Please print)		
Diagnosis		
Date(s) of Admission	Date of Surgery	Type of Surgery
Treatment Being Received and Expected Duration		

9. Is this patient expected to be in need of services when coverage under the new healthcare plan begins or during the next 90 days? Yes No

10. Please list any other continuing care needs that may qualify for Transition of Care Benefits.

_____

_____

_____

I am requesting coverage for continuing care by the provider named above for a condition for which treatment began prior to the Kelsey-Seybold Direct Provider Network effective date. If approved, I understand coverage for continuing care will be covered for a limited period. Further, I hereby authorize the above physician to provide Kelsey-Seybold Clinic or affiliated company with any and all medical information and records necessary to make a coverage determination.	
Signature of Patient *	Date

* If the Patient is a minor, the signature of the parent or guardian is required.

TRANSITION OF CARE BENEFITS

Transition of Care Benefits are intended to assist patients who are in an active course of treatment by an Out-of-Network Provider to continue treatment until medical care is transferred to an In-Network Provider or Hospital. If approved, the Patient will be allowed to continue treatment of a specific illness/acute medical condition with an Out-of-Network Provider for a specified time period. This benefit is granted on a short-term basis for the acute condition only. An In-Network Provider will be responsible for any other medical problems that arise during the period. Once the active course of treatment is completed, the Patient must utilize In-Network Providers for ongoing management of the condition.

IF A PATIENT ANTICIPATES RECEIVING CARE FROM A OUT-OF-NETWORK PROVIDER FOR A QUALIFYING ILLNESS AFTER THE EFFECTIVE DATE, A TRANSITION COVERAGE REQUEST FORM MUST BE SUBMITTED TO KELSEY-SEYBOLD CLINIC.

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

- Any pregnancy in the second or third trimester on the plan effective date
- Newly diagnosed or relapsed cancer in the middle of a course of treatment (radiation therapy or chemotherapy)
- Recent trauma or fracture
- Organ Transplant candidates
- Stroke
- Recent major/minor surgery
- Hospital confinement on the plan effective date

Examples of conditions which can readily be transferred to an In-Network Provider include, but are not limited to:

- Routine exams, vaccinations and health assessments
- Stable chronic conditions, such as diabetes, arthritis, allergies, hypertension, glaucoma
- Acute minor illnesses, such as colds, sore throats, ear infections
- Elective scheduled surgeries, such a removal of lesions, hernia repairs, hysterectomy