## Transition of Care

Transition of care applies to initial participants as of the date the district begins participating in the Texas Schools Health Benefits Program (TSHBP), to new hires and to new dependents entering the plan upon a qualifying event, or in the event the district changes their TSHBP Plan option.

If an employee or covered dependent is undergoing a course of medical treatment at the time of enrolling in a TSHBP Plan option and the doctor is not in the network, ongoing care with the current doctor may be requested for a limited period of time, not to exceed six months. Transition of care benefits may be available if being treated for any of the following conditions by a non-network doctor:

- Pregnancy (third trimester or high risk)
- Newly diagnosed cancer
- Terminal illness
- Recent heart attack
- Other ongoing acute care or behavioral care

To request transition of care benefits, the employee must complete a Transition of Care Request Form. All requests are subject to approval. If the transition of care request is approved, the employee or dependent may continue to see a non-network doctor and receive the Network level of benefits from their selected TSHBP plan. If the transition of care request is denied, the employee or dependent may continue to see their current doctor, however benefits for these services will not be available under the plan.

# Transition of Care/Continuity of Care Request Form

o New TSHBP enrollee (Transition of Care applicant)

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

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|---|---|---|---|
| District Name: | Group #: 50000 | Employee Date of Enrollment in TSHBP Plan (mm/dd/yyyy) | |
| Employee Name | | Employee Social Security | Work Phone |
| Home Address Street | City | State ZIP | Home Phone/Cell Phone |
| Patient's Name | Patient's Social Security# | Patient's Birth Date (mm/dd/yyyy) | Relationship to Employee o Spouse o Dependent o Self |

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date_____(mm/dd/yyyy) oYes oNo
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes, etc. oYes oNo
3. Is the patient currently receiving treatment for an acute condition or trauma? oYes oNo
4. Is the patient scheduled for surgery or hospitalization after your effective date with TSHBP? oYes oNo
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? oYes oNo
6. Is the patient receiving treatment as a result of a recent major surgery? oYes oNo
7. Is the patient receiving dialysis treatment? oYes oNo
8. Is the patient a candidate for an organ transplant? oYes oNo
9. 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.

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10. Please complete the Attending Physician information request below.

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

11. Is this patient expected to be in the hospital when coverage with TSHBP begins or during the next 90 days? oYes oNo
12. 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.

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|---|---|
| I hereby authorize the above health care professional to give 90 Degree Benefits 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 the TSHBP Plan. I understand I am entitled to a copy of this authorization form. | |
| Signature of Patient, Parent or Guardian | Date (mm/dd/yyyy) |

**Submit this request form to:**

90 Degree Benefits
Attention: TSHBP Transition of Care/Continuity of Care
Fax: 806-698-5823
Email: careconnect@90degreebenefits.com

**Transition of Care/Continuity of Care requests will be reviewed within 10 business days of receipt.**