Health Plans

Transition of Care Form

Please answer each question. Incomplete forms will be returned to you for completion and will delay the decision-making process.

Employee Date of Enrollment In IU Health Plans (mm/dd/yy):	
Employee Name:	Employee Social Security Number:
Work Phone:	Home Phone/Cell Phone (include area code):
Home Address: Street City State Zip	
Patient's Name:	Patient's Social Security Number or Alternate ID:
Patient's Date of Birth:	Relationship to Employee: ☐ Spouse ☐ Dependent ☐ Self

1. Is the patient pregnant? ☐ Yes ☐ No
   a. If yes, what is the due date? _____
   b. Is the pregnancy considered high risk? (e.g., multiple births, gestational diabetes) ☐ Yes ☐ No
   c. 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 IU Health Plans? ☐ Yes ☐ No
3. Is the patient involved in a course of chemotherapy, radiation therapy, cancer care 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/substance abuse treatment? ☐ Yes ☐ No
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests transition of care:

_____
_____
_____

9. Please complete the healthcare professional information below:

Group Practice Name:		
Provider Name:	Provider Phone Number (include area code):	
Provider Specialty:		
Provider Office Address:		
Hospital Where Provider Practices:	Hospital Phone (include area code):	
Hospital Address: Street City State Zip		
Reason/Diagnosis:		
Date of Admission (mm/dd/yy):	Date of Surgery:	Type of Surgery:
Treatment Being Received and Expected Duration:		

10. Is this patient expected to be in the hospital when coverage with IU Health Plans begins or within 90 days of the coverage effective date? ☐ Yes ☐ No

11. Please list any other continuing care needs that may qualify for transition of care coverage. Note: if these care needs are not associated with the condition for which you are applying for transition of care, you must complete a separate transition of care form.

_____
_____
_____

I hereby authorize the above healthcare provider to give IU Health Plans Medical Management any and all information and medical records necessary to make an informed decision concerning my request for transition of care.

_____

Signature of Patient, Parent or Guardian Date (mm/dd/yy)

Submit this request form to:

IU Health Plans Medical Management
Fax: 317.962.6219