HIGHMARK® Delaware

APPLICATION FOR TRANSITION OF CARE (TOC) BENEFITS

Under our Transition of Care (TOC) program, if you are applying for Point of Service (POS) coverage you may be eligible to receive In-Network benefits for care you are currently receiving from a provider who is not a member of the POS panel. If you are applying for IPA coverage you may be eligible to receive covered benefits for care you are currently receiving from a provider who is not a member of the IPA panel. You must select a primary care physician from the POS or IPA panel of providers in order to be eligible for the TOC program. If you are applying for TOC with more than one provider, fill out additional applications as needed. We must receive this application before the date your POS or IPA benefits become effective.

EMPLOYEE INFORMATION

EMPLOYER	NAME - last, first, middle initial, jr., sr., etc.	DATE OF HIRE / /
ADDRESS		

HOME TELEPHONE NUMBER - include area code	WORK TELEPHONE NUMBER - include area code	SOCIAL SECURITY NUMBER	BIRTHDATE / /

PATIENT INFORMATION

PATIENT'S RELATIONSHIP TO EMPLOYEE - spouse, daughter, etc.	NAME
ADDRESS	

HOME TELEPHONE NUMBER - include area code	WORK TELEPHONE NUMBER - include area code	SOCIAL SECURITY NUMBER	BIRTHDATE / /

PROVIDER INFORMATION

NAME	TELEPHONE - include area code	SPECIALTY
ADDRESS		

CONDITION/DIAGNOSIS	HOW LONG HAS THE DOCTOR BEEN TREATING THIS PATIENT FOR THE CURRENT CONDITION? YEARS MONTHS	HOW LONG IS TREATMENT EXPECTED TO CONTINUE? YEARS MONTHS
WHAT IS THE NATURE OF TREATMENT?	WHAT IS THE DATE OF THE NEXT APPOINTMENT FOR THE PATIENT?	WAS PATIENT RECENTLY HOSPITALIZED FOR THIS CONDITION? ADMISSION DATE:

DID PATIENT HAVE SURGERY? ❑ YES ❑ NO WHAT TYPE? ______ WHEN? ______	IF PREGNANCY, PLEASE IDENTIFY: INITIAL VISIT DATE: / / DUE DATE: / /	NAME OF HOSPITAL WHERE YOU WILL DELIVER

AUTHORIZED TO RELEASE INFORMATION

We are asking you to release this information only to determine if you eligible for In-Network benefits under the POS or IPA Transition of Care program.

*I authorize the above-named provider to release to my Blue Cross Blue Shield POS or IPA Health Care Plan all information relating to past, present and future health care examinations, condition and/or treatment for the condition I described on this form. I understand that benefits in the Transition of Care program are subject to contractual limitations and exclusions set forth in the subscriber contract. I also understand and agree that benefits in the Transaction of Care program do not extend the contractual benefits in any way except to provide the In-Network level of benefits for a non-panel provider for a temporary time period. I also authorize my POS or IPA Health Care Plan to notify my Primary Care Physician of any TOC approval with the non-panel specialist.

*SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE / /

**If the patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.*

MAIL THIS APPLICATION TO:

Referral Center (1-8-40)
Highmark Blue Cross Blue Shield Delaware
P.O. Box 1991
Wilmington, DE 19899

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association