eba&m Corporation PO Box 5079
Westlake Village, CA 91359
Attn: Continuity of Care
Fax: 714-241-9279

Continuity of Care/Transition of Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care

The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization Provider (PPO Provider), Hospital, or other provider is not participating in the Prudent Buyer provider network.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact EBA&M Customer Service.

Completing the Continuity/Transition of Care Request Form

You may request Continuity/Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. **An acute medical condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a newborn child between the ages of birth and 36 months. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the EBA&M Disease Management department at 1-800-249-8440 x 180
- Or, fax this completed request form to 1-714-241-9279 attn Continuity of Care

Continuity of Care/Transition of Care Request Form Continuity of Care: To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care*

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name: ________
Subscriber's social security #:_____
Subscriber's Employer: _____

Patient's Name: _____
Relationship to Subscriber: _____
Date of Birth: _____
Preferred Phone #: _____

For Network Disruption (PMG, IPA, PPO Provider, or Hospital is not participating with the Prudent Buyer network)

Diagnosis (include pertinent history and physical findings):
_____
_____
_____

1. Do you have an upcoming appointment to see a non-participating specialist? Yes No

2. Are you receiving any of the following services:

Services	
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3. Do you have any hospitalizations, surgeries or procedures scheduled? YES NO

If you answered yes to any of these questions please provide the Name/Phone Number:

Physician name performing visit/surgery/procedure _____
Phone number: _____

Physician name performing visit/surgery/procedure _____
Phone number: _____

Hospital/Facility_____
Phone number: _____

4. Are you taking a medication which required a prior authorization AND was approved by your previous insurance carrier? YES NO
   This means that your physician had to provide additional medical information not listed on the prescription that you take to the pharmacy. We will contact the previous carrier to confirm and honor the previously approved authorization.

   Name of Prescription:_____
   Dose: _____
   Date authorized: _____

_____ I hereby authorize the above provider to give the EBA&M Disease Management Department any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that I am entitled to a copy of this authorization form.
I also authorize EBA&M Corporation to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:
__ Home __ Cell __ Work __ Do NOT leave confidential information on my voice mail