An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 9910, Daytona Beach, FL 32120
www.fhcp.com

Transition of Care Form

Welcome to Florida Health Care Plans! It is the goal of the Transition of Care Team to assist you with transitioning into our network of providers, pharmacies & covered medications. Please complete this form to help us make the transition as seamless as possible.

Instructions – **Please complete the TRANSITION OF CARE FORM with the attached authorization forms; provide as much information as possible. The authorization forms allow the RELEASE & REQUEST of Protected Health Information in order to better assist you. You will be contacted if additional information is needed.**

Please return all forms to the Transition of Care Nurse Navigator by fax at 386-238-3271 or by mail to FHCP Case Management Coordination of Care Department, Attn: TOC Nurse Navigator, PO Box 9910, Daytona Beach, FL 32120.

Questions can be directed to Case Management (CM) Coordination of Care Department at 855-205-7293 or to the Transition of Care line at 386-615-5017. Hours of operation are Monday through Friday, 8:00 am to 5:00 pm. The hearing impaired may call TRS Relay 711. We are happy to assist you in transitioning into your health coverage with Florida Health Care Plans.

Member Name: ______________________ **Member #:** ______________
DOB: ________________ **Gender:** ______________
Address: ____
____
Preferred Phone #: ______________________________
Alternative Phone #: ______________________________
Email Address: ______________________________
Emergency Contact (Name, Relationship & Phone #):

Name	Relationship	Phone #

If you wish for your Protected Health Information (PHI) to be released to others, please complete, sign and return the attached Authorization to <u>Release</u> PHI form.

Current Medical Concerns - ____
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PCP (Name, Phone #, City & State) - ______________________________
____

Last Visit - ______________________________

SPECIALISTS (Name, Specialty, Phone #, City & State, Hospital/Group Affiliation)-

Name	Specialty	Phone	City/State	Hospital/Group Affiliation

UPCOMING APPOINTMENTS or PROCEDURES please use the NOTES section on page 4 if additional space is needed -

Date	Provider	Procedure	Visit Type

RECENT VISITS TO EMERGENCY ROOM or URGENT CARE? (Date, Name/Location of ER or UC, Reason for Visit) -

Date	Name/Location	Reason

In order for FHCP to request your medical records from your out-of-network providers, please complete, sign & return the attached AUTHORIZATION TO REQUEST PHI Form.

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CURRENT MEDICATIONS (Drug Name, Dose, Frequency, Prescribing Provider Name) – If you are submitting a Medication Transition Form, skip this section. Please note if free samples or enrolled with patient assistance programs.

Drug name	Dose	Frequency	Prescribing Doctor

Current Pharmacies Used (Name, Location & Phone #, Samples, or Patient Assistance Program)

Pharmacy/Patient Assistance program/Samples from	Location	Phone

DURABLE MEDICAL EQUIPMENT & OTHER MEDICAL SUPPLIES (Oxygen, CPAP, Insulin Pump, Ostomy supplies etc.). Please include name of supplier & prescribing provider. –

DME/Supplies	Company/Supplier	Contact number	Prescribing Provider

Are you in danger of running out of any medication, DME or medical supply in the near future or soon after your effective date with FHCP? ☐ **YES** ☐ **NO**

If YES, please list the name of the medication, medical equipment, or supply with the approximate date you will be without.

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NOTES:

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Disclaimer – Standard Prior Authorization procedures & guidelines apply. Transition of Care is a service for new members transitioning into the FHCP network. Submitting this form does not guarantee continued care with out-of-network providers, pharmacies, medical suppliers, or coverage of non-formulary medications. You may be financially responsible for charges if you receive services outside of the FHCP network without an approved authorization. It is your responsibility to notify your providers of your insurance change.

TOC RN Navigator Use Only:

PLAN TYPE (Circle One) – MCARE / QHP / SELF / COMM
GROUP - ____
PLAN CODE - ____________________________________
HMO, POS, TROP (Circle One)
RIDERS – ____
EFF - ____

TO DO:
ROI forms received? □ **YES** □ **NO**
ROI forms in EHR? □ **YES** □ **NO**

- □ **Tasked Med Rec Team in EHR to obtain records.**
- □ **Reviewed TOC Form**
- □ **Initial Call w/Member**
- □ **Discuss PAR Pharms – Closest =** ______________________________
- □ **Mail Order Pharmacy Information Given**
- □ **Discuss closest EHCC – Closest =** ______________________________
- □ **Identify Rx needing PAs, formulary exceptions.**
- □ **Contact Pharm Svcs for comparable form meds if non-form meds exist.**
- □ **Notify Referrals of potential incoming PA reqs.**
- □ **Task COC CM for complex issues & CRC needs.**
- □ **Task UR CM for ongoing In-Pt, HH or SNF.**

BENEFITS:

DEDUCTIBLE = ______________	**MOOP =** ______________
PCP COPAY = ______________	**SPECIALIST COPAY =** ______________
EHCC COPAY = ______________	**U/C COPAY =** ______________
ER FACILITY COPAY = ______________	**ER PROVIDER COPAY =** ______________
AMBULANCE COPAY = ______________	