Continuity of Care Form

motivhealth®

Transition of Care

Transition of Care gives new MotivHealth members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition until the safe transfer to a network health care professional can be arranged. Examples of covered medical conditions can be found later in this document. You must apply for Transition of Care no later than thirty (30) days after the date your coverage begins with MotivHealth.

Continuity of Care

Continuity of Care gives MotivHealth members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time.

Examples of covered medical conditions can be found below.

If your health care professional is leaving the MotivHealth network, or if you are a new MotivHealth member, you must apply for Continuity of Care or Transition of Care within thirty (30) days of the health care professional's termination date or within thirty (30) days of your effective date, using the form below.

How Transition of Care and Continuity of Care Works

You must already be under active and current treatment (see definition below) by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity of Care form below.

Your request will be evaluated based on applicable Federal law, plan benefits and accreditation standards. Coverage at the network level is available if the provider agrees to accept MotivHealth network rates, provide medical records, follow our policies and a treatment plan approved by us.

- If your request is approved for the medical condition(s) listed in your form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the health care professional for:
    - Up to 30 days from the effective date of coverage for new members,
    - Up to 90 days from when your provider leaves your health plan network, or
    - Through completion of the current active course of treatment period, whichever comes first.
- If your request is received after the above time-frames, you will not be eligible for Transition of Care or Continuity of Care.
- After this time, network coverage ends. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame we approve, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements.
- All other services or supplies must be provided by a network health care professional for you to receive network coverage levels.
- If your plan does not include out-of-network coverage, you can call the number on the back of your health plan ID card for assistance.

- The availability of Transition of Care and Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

Examples of medical conditions that may qualify for Transition of Care and Continuity of Care include, but are not limited to:

- Pregnant and undergoing course of treatment for pregnancy.
    - Coverage for newborn children begins at the moment of birth and continues for thirty (30) days. You must select an in-network pediatrician and notify your health plan representative within thirty (30) days from the baby's date of birth to add the baby to your plan.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six (6) to eight (8) weeks after surgery).
- Serious acute conditions in active treatment such as heart attacks or strokes.
- Other serious chronic conditions that require active treatment.

Examples of conditions that do not qualify for Transition of Care and Continuity of Care include:

- Routine exams, vaccinations and health assessments.
- Chronic conditions such as diabetes, arthritis, allergies, asthma, kidney disease and hypertension that are stable.
- Minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries.

Frequently Asked Questions

Q: What can I expect after the completed form is submitted?

A: You will receive a written decision either approving or denying your request. We encourage you to find a doctor, health care professional or facility (like a hospital) in your network at motivhealth.com.

Q: If I am approved for Transition of Care and Continuity of Care for one medical condition, can I receive network coverage for a non-related condition?

A: No. Network coverage levels provided as part of Transition of Care and Continuity of Care are for the specific medical conditions only and cannot be applied to another condition. If you are seeking network level of benefits for more than one medical condition, you will need to complete a separate request for each specific condition.

Definitions

Transition of Care: Gives new MotivHealth members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition, until the safe transfer to a network health care professional can be arranged.

Continuity of Care: Gives MotivHealth members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Out-of-network: Services provided by a non-participating provider.
Pre-authorization: An assessment for coverage under your health plan before you can get access to medicine or services.

Active course of treatment: An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally, an active course of treatment is defined as within the last thirty (30) days, but is evaluated on a case-by-case basis.

Transition of Care and Continuity of Care Form

To complete this form:

- Please make sure all fields are completed. When the form is complete, it must be signed by the member for whom the Transition of Care and Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for Transition of Care and Continuity of Care within thirty (30) days of the effective date of coverage or within thirty (30) days of the care provider's termination date.
- A separate Transition of Care and Continuity of Care form must be completed for each condition for which you and/or your dependents are seeking Transition of Care and Continuity of Care.
- Please mail or fax the completed form along with relevant medical records and information, within thirty (30) days following the effective date of your MotivHealth plan to:

  MotivHealth Insurance Company
  PO Box 709718
  Sandy, UT 84070
  Attn: Transition of Care/Continuity of Care
  Fax: 844-533-1289
  Email: correspondence@motivhealth.com

After receiving your request, MotivHealth will review and evaluate the information provided. Incomplete forms will be returned to the requester. If the form is complete, we will send you a letter to let you know if your request was approved or denied. Completion of this form does not guarantee that a Transition of Care and Continuity of Care request will be granted.

Member Information

☐ **New MotivHealth Member** (Transition of Care Applicant) Provider Termination Date: _____

☐ **Existing MotivHealth Member whose care provider terminated** (Continuity of Care Applicant)

Name of Person Being Treated: _____ MotivHealth ID #: _____

Date of Birth (mm/dd/yyyy): _____ Street Address: _____

City: _____ State: _____ ZIP: _____

Home/Cell Phone Number: _____ Work Phone Number: _____

Employer Name: _____ Date of Enrollment in MotivHealth Plan: _____

Member's Relationship to Employee:

☐ Self ☐ Spouse

☐ Dependent ☐ Other

Is the member currently covered by another health insurance carrier?

☐ Yes ☐ No

If yes, carrier name: _____

Authorization to Release Records:

I authorize all physicians and other health care professionals or facilities to provide MotivHealth information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Transition of Care/Continuity of Care benefits under the plan.

Member's Signature or Parent or Guardian's Signature if member is a minor: _____

Date (mm/dd/yyyy): _____

Care Provider Section: Your healthcare professional should comlete the following information.

Name of Treating Physician or other Healthcare Professional: _____

National Provider Identifier (NPI) or Tax ID Number (TIN): _____

Phone Number: _____ Street Address: _____

City: _____ State: _____ ZIP: _____

Facility Name: _____ Facility NPI or TIN: _____ Facility Phone: _____

Date of Last Visit: _____ Next Scheduled Appointment: _____ If Maternity, Expected Due Date: _____

Please select one of the descriptions if it applies:

☐ Life-threatening condition ☐ Acute condition ☐ Transplant ☐ Inpatient/Confined

☐ Upcoming surgery ☐ Disabled/Disability ☐ Terminal illness ☐ Ongoing treatment

Newborn Members: Coverage for newborns begins at the moment of birth and continues for 30 days. You must select a network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

Is the treatment for an exacerbation of a previous injury or chronic condition? ☐ Yes ☐ No

Current Condition and Associated Treatment Plan (include a brief statement and all relevant CPT codes*: _____

_____

_____

_____

If these care needs are not associated with the condition for which you are requesting Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition.

*Attach additional clinical as needed.

We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time-frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered. Please note the following:

For providers leaving our network: The terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any co-payment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Healthcare Professional: _____

Date (mm/dd/yyyy): _____