NON-PARTICIPATING PROVIDER TRANSITION-OF-CARE FORM

AvMed • Fax 1-800-552-8633

If you require assistance with transition of care from your non-participating provider to an AvMed participating provider, please complete this form and fax it to the number above. This information is NOT used to determine eligibility – it is to assist us in arranging a smooth transition of your medical care to AvMed providers. This service is available during the first 30 days from your effective date with AvMed.

Si usted necesita ayuda para completar este documento, por favor llame a nuestro Departamento de Servicios a los Afiliados utilizando el número de su tarjeta de identificación. Un representante que habla español le ayudará.

Sales representative_____ Employer group_____

Employee/policy holder name_____ Employee SS#_____ - _____ - _____

Member Information

Last name	First name	MI	Date of birth
Street address	City	State	ZIP code
Work phone #	Home phone #	Today's date	SS#
Relationship to employee Spouse – Child – Other		AvMed effective date	

I. Current Ongoing Medical Treatment

Non-Participating Providers

Name_____ Address_____

Phone #_____ Illness/Treatment_____

Name_____ Address_____

Phone #_____ Illness/Treatment_____

Name_____ Address_____

Phone #_____ Illness/Treatment_____

Other_____

Transplant Y ☐ N ☐ If yes, date of transplant_____ Pending Transplant Y ☐ N ☐

Current Dialysis Y ☐ N ☐ **Diabetes** Y ☐ N ☐ **Do you have a Blood Glucose meter?** Y ☐ N ☐

If yes, what type?_____

II. Are you pregnant and using a Non-Participating Provider/Hospital? Y ☐ N ☐

If yes, due date_____ Provider's Name/Phone #_____

Hospital's name_____ High-risk pregnancy? Y ☐ N ☐

III. Current Medical Services (So we may assist in the transition to your new group coverage.)

Home Care: Y ☐ N ☐ If yes, name of agency_____ Phone #_____

For what reason? (therapy, nursing, IV, wound care, etc.)_____

Are you currently being treated at any wound care center or hyperbaric oxygen center? Y ☐ N ☐

Current durable medical equipment Y ☐ N ☐ If yes, what type? CPAP____ Oxygen____ Hospital Bed____

Other_____

Name of Vendor_____ Phone #_____

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider to release for review my or my enrolled dependent children's (under age 18) medical records to AvMed. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children for treatment, payment and health care operations.

X_____

Member Signature Date

If you have any questions regarding this form, please call Member Services at 1-800-882-8633.