Transition of Care/Continuity of Care request form

See instructions for completing this form on the reverse side.

❑ New Cigna enrollee (Transition of Care applicant)

❑ Existing Cigna customer whose health care provider terminated (Continuity of Care applicant)

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employer	Policy/Plan #	Employee Date of Enrollment in Plan (mm/dd/yyyy)
Employee Name	Employee Member ID	Work Phone
Home Address Street City State ZIP		Home Phone/Mobile
Patient's Name	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee ❑ Spouse ❑ Dependent ❑ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date _____(mm/dd/yyyy) ❑ Yes ❑ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ❑ Yes ❑ No
3. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Cigna? ❑ Yes ❑ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ❑ Yes ❑ No
6. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ❑ No
7. Is the patient receiving dialysis treatment? ❑ Yes ❑ No
8. Is the patient a candidate for an organ transplant? ❑ Yes ❑ No
9. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

_____

10. Please complete the health care provider information requested below.

Group Practice Name		
Health Care Provider Name		Health Care Provider Phone #
Health Care Provider Specialty		
Health Care Provider Address		
Hospital Where Health Care Provider Practices		Hospital Phone #
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when coverage through Cigna begins or during the next 90 days? ❑ Yes ❑ No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care, you need to complete a separate Transition of Care/Continuity of Care request form.

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13. Is the patient receiving mental health/substance use treatment? ❑ Yes ❑ No

I hereby authorize the above health care provider to give Cigna Health and Life Insurance Company or its affiliates and contracted parties 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 I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive, Pittsburgh, PA 15275
Fax 866.729.0432

Transition of Care/Continuity of Care requests will be reviewed within 15 days of receipt. For new Cigna customers, review will occur within 15 days of participant's effective date. Review for organ transplant requests may take longer than 10 days.

Instructions for completing the Transition of Care/Continuity of Care request form

Note: Do not use this form if you are enrolled in a Cigna HealthCare of California, Inc. plan and are seeking a Transition of Care. Contact Cigna for a Cigna HealthCare of California, Inc. Transition of Care brochure.

A separate Transition of Care/Continuity of Care request form must be completed for each condition for which you and/or your covered dependents are seeking Transition of Care/Continuity of Care. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Transition of Care/Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.

To help ensure a timely review of your request, please return the form as soon as possible. You must apply for Transition of Care/Continuity of Care within 60 days of the effective date of your plan, or within 60 days of your provider's termination date.

The first few sections of the form apply to the employee. When the form asks for the patient's name, enter the name of the person who is receiving care and is requesting Transition of Care/Continuity of Care.

If you answered yes to questions #1, #2, #3, #4, #5, #6, #7 or #8, please submit this request form to:

Cigna Health Facilitation Center
Attention: Transition of Care/Continuity of Care Unit
3200 Park Lane Drive
Pittsburgh, PA 15275
Fax: 866.729.0432

In #9, include information about the current or proposed treatment plan and the length of time treatment is expected to continue. If surgery has been planned, state the type and the proposed date of the surgery.

In #12, briefly state the health condition, when it began, what health care provider is currently involved, and how often you see this health care provider. Please be as specific as possible.

In #13, if you answered Yes for customers receiving mental health services:

1. If you are receiving outpatient mental health services, you should do one of the following.
   - If your employer introduced a Cigna plan as a new option during your group's open enrollment period, you are not required to submit a Transition of Care/Continuity of Care request form.
   - If you are a new hire or you have recently selected a Cigna plan option already offered by your employer, you will need to complete the Transition of Care/Continuity of Care request form and submit this form to your Cigna claim office. The address is PO Box 18223, Chattanooga, TN 37422-7223.
2. If you are receiving inpatient, residential, partial hospitalization or intensive outpatient services, regardless of your plan type, call (or have your health care professional call) the customer service number on the back of your Cigna ID card, or call **800.244.6224** if you have not received your ID card.

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