



### Transition of Care Form

Please answer each question. Incomplete forms will be returned to you for completion and will delay the decision-making process.

Employee Date of Enrollment In IU Health Plans (mm/dd/yy):			
Employee Name:		Employee Social Security Number:	
Work Phone:		Home Phone/Cell Phone (include area code):	
Home Address: Street	City	State	Zip
Patient's Name:		Patient's Social Security Number or Alternate ID:	
Patient's Date of Birth:		Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Self	

1. Is the patient pregnant?  Yes  No
  - a. If yes, what is the due date? \_\_\_\_\_
  - b. Is the pregnancy considered high risk? (e.g., multiple births, gestational diabetes)  Yes  No
  - c. Is the patient currently receiving treatment for an acute condition or trauma?  Yes  No
2. Is the patient scheduled for surgery or hospitalization after your effective date with IU Health Plans?  Yes  No
3. Is the patient involved in a course of chemotherapy, radiation therapy, cancer care or terminal care?  Yes  No
4. Is the patient receiving treatment as a result of a recent major surgery?  Yes  No
5. Is the patient receiving dialysis treatment?  Yes  No
6. Is the patient a candidate for an organ transplant?  Yes  No
7. Is the patient receiving mental health/substance abuse treatment?  Yes  No
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests transition of care:

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9. Please complete the healthcare professional information below:

Group Practice Name:			
Provider Name:		Provider Phone Number (include area code):	
Provider Specialty:			
Provider Office Address:			
Hospital Where Provider Practices:		Hospital Phone (include area code):	
Hospital Address:			
Street	City	State	Zip
Reason/Diagnosis:			
Date of Admission (mm/dd/yy):	Date of Surgery:	Type of Surgery:	
Treatment Being Received and Expected Duration:			

10. Is this patient expected to be in the hospital when coverage with IU Health Plans begins or within 90 days of the coverage effective date?  Yes  No

11. Please list any other continuing care needs that may qualify for transition of care coverage. Note: if these care needs are not associated with the condition for which you are applying for transition of care, you must complete a separate transition of care form.

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I hereby authorize the above healthcare provider to give IU Health Plans Medical Management any and all information and medical records necessary to make an informed decision concerning my request for transition of care.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

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Date (mm/dd/yy)

**Submit this request form to:**

IU Health Plans Medical Management  
Fax: 317.962.6219