DetegoHealth
Discover A Better Plan

Transition of Care/Continuity of Care Request Form

Please check one:

- ☐ I am a new plan member (Transition of Care applicant)
- ☐ I am an existing plan member. My designated provider network recently changed
- ☐ I am an existing plan member whose provider recently terminated or is terminating with my designated provider network

Effective Date of Change (MM/DD/YYYY): _____

Patient Information			
Employee/Participant Name		ID Number	
Patient Name		Patient Date of Birth	Relationship
Patient Address	City	State	Zip Code
Patient Primary Number		Patient Email Address	

Medical Information				
1. Is this patient pregnant and in the second or third trimester of pregnancy? Due Date: _____	☐	Yes	☐	No
2. Is the patient pregnant and considered high risk?	☐	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 the effective date of change above?	☐	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 a organ transplant?	☐	Yes	☐	No
9. If you did not answer “Yes” to any of the above questions, please name the condition for which you are requesting Transition/Continuity of Care:				
10. Date of Diagnosis	MM/DD/YYYY			
11. Treatment being received and expected duration:				
12. List any scheduled treatments and date(s) scheduled:				

Who is or will no longer be in-network? Please check one. If multiple answers apply, a separate form will be required for each.

- ☐ Provider
- ☐ Facility
- ☐ Other _____

Provider Information			
Provider/Facility Name			
Provider/Facility Address	City	State	Zip Code
Provider/Facility Phone Number		Provider/Facility Specialty	
If applicable, Hospital where Provider practices		Hospital Phone Number	
Hospital Address	City	State	Zip Code

Patient Authorization	
I hereby authorize the above provider and/or facility to give Detego Health 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.	
Patient Name (Please Print)	Date (MM/DD/YYYY)
Patient Signature, Parent, or Guardian	Date (MM/DD/YYYY)

Submit this request form to:

Detego Health: Transition of Care/Continuity of Care Department
Mail: 377B Lear Rd. #226, Avon Lake, OH 44012-1473
Email: MemberServices@detegohealth.com
Fax: 855 962 4655