MedStar Medicare Choice

# TRANSITION OF CARE APPLICATION

Dear Member:

Thank you for enrolling in MedStar Medicare Choice.

You may currently be receiving services from healthcare providers that are not part of the MedStar Medicare Choice Provider Network. An approved Transition of Care request allows you, as a new member, to continue care for a medical condition, under certain circumstances and for a specified period of time, with a specialist or at a hospital or facility outside of the MedStar Medicare Choice Provider Network. Transition of Care is intended primarily for members who are in *active, ongoing treatment* with a non-participating provider and whose treatment will continue for a specific period of time following enrollment in MedStar Medicare Choice.

If you have any questions about your benefits or services, please contact one of our MedStar Medicare Choice Member Services Representatives at 855.222.1041. We are available to take your call:
Oct. 1 through Feb. 14: 8 a.m. to 8 p.m., seven days a week
Feb.15 through Sept. 30: 8 a.m. to 8 p.m., Monday through Friday, and 8 a.m. to 3 p.m. on Saturday.

Our representatives are available to help you find a doctor or facility in your area that is part of our comprehensive network of leading physicians and hospitals.

If you would like to submit a request to continue treatment with your current provider for a current, ongoing medical condition, please complete this Transition of Care request. Completed requests must be sent within 90 days after the effective date of your coverage under MedStar Medicare Choice. Incomplete information will delay the Transition of Care review process.

Mail the completed form to:
Attention: Clinical
Management
MedStar Medicare Choice
950 N. Meridian St.
Suite 600
Indianapolis, IN 46204

Or fax the completed form to: 855.431.8762

If you have questions about completing this form, please contact one of our MedStar Medicare Choice Member Services Representatives for assistance at 855.222.1041. TTY users should contact 855.250.5604. If you have been designated as a MedStar Medicare Choice member's personal representative to act on their behalf in discussing their health information and benefit coverage, please include the date that the Personal Representative Designation Form (PRDF) was sent to MedStar Medicare Choice. If you need a copy of a PRDF, you may obtain one by calling a Member Services Representative.

MedStar Medicare Choice

# TRANSITION OF CARE APPLICATION

**TO BE COMPLETED ONLY BY MEMBERS WHO ARE REQUESTING TRANSITION OF CARE**

Please complete a separate form for each covered dependent.

**Self O** **Spouse O** **Other O**

| | |
|---|---|
| Member Name | |
| Member Address | |
| Member ID # | Leave blank if you have not yet received your member ID number. |
| Daytime Phone # | |
| Evening Phone # | |
| Date of Birth | |
| Social Security # | |

**Reason for Requesting Transition of Care**

I am requesting Transition of Care to continue treatment for the following illness(es), condition(s) or healthcare service(s) (be specific):

MedStar Medicare Choice

# TRANSITION OF CARE APPLICATION

| About the member whose records are being requested: | |
|---|---|
| **Member Name** | **Member ID** |
| | Leave blank if you have not yet received your member ID number. |

**Protected Health Information (PHI) Disclosure Consent Form**
If you are completing and signing this form for a member who is a minor or a covered dependent who is legally incompetent, provide your name, address, and relationship to the member.

Name:
_____

Address:
_____

City/State/Zip:
_____

Phone Number:
_____

If applicable, relationship to the member:
_____

MedStar Medicare Choice

# TRANSITION OF CARE APPLICATION

**Authorized Healthcare Providers**
To review your request, we will need to ask the provider(s) whom you identify below to disclose protected health information (PHI) from your medical records and/or charts. MedStar Medicare Choice will respect your privacy and keep your records properly protected as directed by HIPAA (Health Insurance Portability and Accountability Act) regulations.

| **List the providers from whom we may obtain your PHI:** | | | |
|---|---|---|---|
| Provider Name: | | | |
| Provider Address: | | | |
| City: | | | |
| State: | | | |
| Zip: | | | |
| Phone Number: | | | |
| Fax Number: | | | |

I,_____, authorize the providers I've named to disclose my PHI to the Medical Management Department at MedStar Medicare Choice, my health insurance carrier. I understand that MedStar Medicare Choice's Medical Management Department will review my PHI as part of the Transition of Care process.

**If you are requesting Transition of Care, check each box to indicate that you have read and understand the content. Please sign and date the form.**

☐ Purpose of Disclosure

The purpose of this request and consent for disclosure is to allow MedStar Medicare Choice to receive all pertinent PHI needed to review and make a decision concerning this request for Transition of Care.

☐ Expiration of Consent

The use of the consent of disclosure of the PHI in this form expires 60 days from the date of the member's signature below.

MedStar Medicare Choice

**TRANSITION OF CARE APPLICATION**

☐ Need for Renewal of Consent

If I do not revoke this consent, I understand that it will expire on the expiration date indicated below. If I wish to extend the consent, I must renew the consent by completing a new consent form.

☐ Right to Revocation

I understand that I have the right to revoke this consent at any time. I understand that in order to revoke this consent, I must do so in writing and submit my written revocation to MedStar Medicare Choice Member Services Department and to the healthcare provider(s) indicated on this form. I understand that this revocation will not apply to information that has already been released in response to this consent.

☐ Right to Retain a Copy of this Consent

Please check here if you are not making a copy of this consent form for your own records, and wish to receive a copy from MedStar Medicare Choice network. I understand that I have the right to retain or receive a copy of this consent.

Signature_____

Date_____

MedStar Medicare Choice

# TRANSITION OF CARE APPLICATION

**Nondiscrimination Notice**

MedStar Medicare Choice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MedStar Medicare Choice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
MedStar Medicare Choice:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at **855-222-1041** (TTY users should call **855-250-5604**). Our hours of operation change twice a year. You can call us October 1 through February 14, seven days a week from 8 a.m. to 8 p.m. From February 15 through September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m., and Saturday from 8 a.m. to 3 p.m.

If you believe that MedStar Medicare Choice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Catherine Kajubi, JD, Director of Medicare Compliance, 5233 King Ave., Suite 400, Baltimore, MD 21237-4001, Fax Number: **410-350-7440**, **Catherine.M.Kajubi@medstar.net**.
You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Catherine Kajubi, JD, Director of Medicare Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1–800–368–1019**, **800–537–7697** (TDD).
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

**Translation Services**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-222-1041 (TTY: 1-855-250-5604).

**ማስታወሻ**: **የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ** 1-855-222-1041 (**መስማት ለተሳናቸው**: 1-855-250-5604).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-222-1041（TTY：1-855-250-5604）。

MedStar Medicare Choice

**TRANSITION OF CARE APPLICATION**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-222-1041 (ATS: 1-855-250-5604).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-222-1041 (TTY: 1-855-250-5604).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-222-1041 (телетайп: 1-855-250-5604).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-222-1041 (TTY: 1-855-250-5604).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-222-1041 (TTY: 1-855-250-5604).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-222-1041 (TTY: 1-855-250-5604).

Dè dɛ nià kɛ dyédé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-855-222-1041 (TTY: 1-855-250-5604)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-855-222-1041 (TTY: 1-855-250-5604).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-855-222-1041 (TTY: 1-855-250-5604).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-222-1041 （TTY：1-855-250-5604）।

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-222-1041（TTY: 1-855-250-5604）まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-222-1041 (TTY: 1-855-250-5604) 번으로 전화해 주십시오.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-222-1041 (TTY: 1-855-250-5604).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur

Verfügung. Rufnummer: 1-855-222-1041 (TTY: 1-855-250-5604).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-222-1041 (رقم هاتف الصم والبكم: 1-855-250-5604).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-222-1041 (TTY: 1-855-250-5604).

**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-222-1041 (TTY: 1-855-250-5604) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-222-1041 (TTY: 1-855-250-5604).

**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-855-222-1041 (TTY: 1-855-250-5604).