What is Transition of Care/Continuity of Care?

With Transition of Care/Continuity of Care, you may be able to continue to receive services for specified medical conditions with health care providers who are not in the HonorHealth and Innovation Care Partners (ICP) network at the gap approved benefit level. This care is for a defined period-of-time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care/Continuity of Care at enrollment, or when there is a change in your medical plan. You must apply no later than December 31, 2023.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy through first postpartum visit
- Cancer during chemotherapy, radiation or reconstruction
- Transplant
- Recent major surgeries still in a follow-up period
- Acute conditions in active treatment such as heart attacks, strokes, or unstable chronic conditions
- Care under a previously approved gap
- Outpatient intravenous therapy for a resolving condition
- Terminal illness with an anticipated life expectancy of six (6) months or less
- Staged surgeries, such as cleft palate repair

Examples of conditions that do not qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Primary care visits
- Routine exams, vaccinations and health assessments.
- Preference for an out-of-network specialist when specialty is available in-network

What time frame is allowed for transitioning to a new in-network health care provider?

If it is determined that transitioning to an in-network health care provider is inappropriate or unsafe for the conditions that qualify, services by the approved Blue Cross Blue Shield of AZ health care provider will be authorized for a specified period of time (usually 90 days). Or, services will be approved until care has been completed or transitioned to an in-network health care provider, whichever comes first.

If I am approved for Transition of Care/Continuity of Care for one illness, can I receive in-network coverage for a non-related condition?

Gap approved benefit levels provided as part of Transition of Care/Continuity of Care are for the specific illness or condition only and cannot be applied to another illness or condition. You need to complete a Transition of Care/Continuity of Care form for each unrelated illness or condition. You need to complete this form no later than December 31, 2023.

Can I apply for Transition of Care/Continuity of Care if I am not currently in treatment or seeing a health care provider?

You must already be in treatment for the condition that is noted on the Transition of Care/Continuity of Care form.

How do I apply for Transition of Care/Continuity of Care coverage?

Requests must be submitted in writing, using the Transition of Care/Continuity of Care form. This form must be submitted at the time of enrollment, but no later than December 31, 2023, change in medical plan, or when your health care provider leaves the HonorHealth and ICP network. After receiving your request, those that need review for medical necessity will be evaluated by ICP for conditions that do not meet plan criteria as outlined above. You will be notified of the determination within 7 to 10 business days of submitting your form to ICP.

HonorHealth Employee Health Plan
Transition of Care/Continuity of Care Form
Personal & Confidential

This form is a formal request for HonorHealth Employee Health Plan to cover continuing care from an out of network (outside ICP network) provider from whom you have been receiving treatment for a period not to exceed 90-days from the effective date of this change. If the coverage is not approved, care by the non-participating provider after the plan's effective date will not be covered.

Employees should complete the following sections to the best of your ability:

1. Reason for Transition of Care/Continuity of Care
2. Section 1 (Employer information)
3. Section 2 (Subscriber/Member information)
4. Section 3 (Authorization) Read the authorization, name and date the form (if patient is age 17 or older, he or she must be listed)
5. Section 4 (Provider information) Provide the name and information of the treating physician and condition being treated
6. Fax the completed form to Innovation Care Partners for review. The fax number is 480-588-8061

REASONS for Transition of Care/Continuity of Care and Information Required:

Please check appropriate box:

Reason for Request	Dates	Treating Specialist	Other details
☐ Pregnancy (through first postpartum visit)	Estimated due date:	Name: Specialty:	
☐ Cancer during chemotherapy, radiation or reconstruction (through active treatment phase)	Estimated duration of active cancer treatment:	Name: Specialty:	Type of cancer: Type of treatment (Chemo, radiation, surgery):
☐ Transplant (up to 1-year post-transplant)	Date of transplant:	Name: Specialty:	Type of transplant (organ):
☐ Recent major surgery still in a follow-up period (90-day transition)	Date of surgery:	Name: Specialty:	Type of surgery:
☐ Acute conditions in active treatment such as heart attacks, strokes, or unstable chronic conditions (90-day transition)	Date of episode:	Name: Specialty:	Diagnosis:

☐ Outpatient intravenous therapy for a resolving condition	Date of diagnosis: Expected date of therapy completion:	Name: Specialty:	Diagnosis: IV therapy name:
☐ Partially completed staged surgeries (for example cleft palate repair)	Date of initial surgery: Estimated date(s) of remainder of surgeries:	Name: Specialty:	Diagnosis:
☐ Terminal illness treatment with anticipated life expectancy of 6 months or less	Date of diagnosis:	Name: Specialty:	Diagnosis: Treatment plan:
☐ Care under a previously approved gap (i.e. member out of state, or specialized services not available in-network)	Date care gap approved:	Name: Specialty:	Reason for gap:

Please note - A preference to continue care with an out-of-network provider without clear medical necessity, such as the above conditions, will be subject to the plan benefit coverage restrictions.

☐ I do not meet any of these conditions and am requesting a gap for the following reason:

If your conditions do not meet medical necessity for a Transitions of Care/Continuity of Care, you will be notified, and assistance will be provided to choose an in-network provider.

1. Employer Information	Employer's Name (Please print) **HonorHealth**		Plan Effective Date (Required) **1/1/2024**
2. Subscriber/ Member Information	Subscriber's Name (Please print)		Subscriber's Member ID Number
	Subscriber's Address (Please print)		
	Member's Name (Please print)	Birthdate (MM/DD/YYYY)	Telephone Number

HonorHealth Employee Health Plan
Transition of Care/Continuity of Care Form
Personal & Confidential

<table>
<tr><td rowspan="2">3. Authorization</td><td colspan="2">I am requesting authorization for coverage of continuing care from the out of network healthcare provider named below for treatment which was initiated prior to your plan effective date. If approved, I understand that the authorization for services specified below will be covered for a limited period as approved by ICP. In addition, I authorize the health care provider to send medical information and/or records requested by Innovation Care Partners that are needed to make a coverage determination.</td></tr>
<tr><td>Patients name (Required if Patient is 17 or Older)</td><td>Date</td></tr>
<tr><td rowspan="5">4. Physician Information</td><td>Name of Out of Network Treating Physician or other healthcare professional (Please print)</td><td>Telephone Number</td></tr>
<tr><td colspan="2">Address of Out of Network Treating Physician or other healthcare professional (Please print)</td></tr>
<tr><td colspan="2">Diagnosis/Condition being treated:</td></tr>
<tr><td colspan="2">Treatment Plan/Duration:</td></tr>
<tr><td colspan="2">Date of initiation of Treatment:</td></tr>
</table>

FOR ICP USE ONLY:

Approve: YES _______ NO ________
Duration: _______
Date Approved/Denied: __________
Approved/Denied By: ___________