Transition of Care Request

Personal & Confdential

AmeriBen

This form is a formal request for Emory Healthcare and Emory University Employee Health and Welfare Plan to cover continuing care from an out of network doctor or from certain other healthcare professionals (see related Transition Coverage Questions and Answers) from whom you have been receiving treatment. If the coverage is not approved, care by the non-participating provider after the plan's effective date will be covered at the non-preferred rate. Please complete the following sections:

1. Section 1 (Employer Information)
2. Section 2 (Subscriber/Member Information)
3. Section 3 (Authorization) Read the authorization, sign and date the form (if patient is age 18 or older, he or she must also sign and date this form).
4. Give the form to the member's out of network provider to complete Section 4 (Physician Information)
5. Submit the completed form to AmeriBen shown below.

1. Employer Information	Employer's Name (Please Print)		Plan Effective Date (Required)
2. Subscriber/Member Information	Subscriber's Name (Please Print)		Subscribers Social Security Nimber
	Subscriber's Address (Please Print)		
	Member's Name (Please Print)	Birthdate (MM/DD/YYYY)	Telephone Number
3. Authorization	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 1/01/2027. If approved, I understand that the authorization for services specified below will be covered for a limited period of time (365 days). In addition, I authorize the health care provider to send medical information and/or records requested by AmeriBen that are needed to make a coverage determination.		
	Patient's Signature (Required if patient is 18 or older)		Date
	Parent's Signature (Required if patient is 16 or younger)		Date
4. Physician Information	Name of Out of Network Treating Physician or other healthcare professional (Please Print)		Telephone Number
	Address of Out of Network Treating Physician of other healthcare professional (Please print)		Physician's TIN
	Signature of Out of Network Treating Physician or othe healthcare professional		Date
Please provide all specific information to avoid delay in processing this request	The above named patient will become a Emory Healthcare or Emory University Employee Health and Welfare Plan member as of the effective date indicated above. Although you are not participating provider in the Plan's network, the member has requested that we cover care provided by you for a specific period of time because of a condition requiring an active course of treatment, or the member is in the third trimester of pregnancy that began prior to the Plan effective date. An active course of treatment is defined as: "A planned program of services rendered by a health care provider starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment". Please include a brief statement of the member's current condition and treatment plan. For pregnancies please indicate the estimated date of condition (EDC). In the event this request is approved you agree that you will not seek payment from the member for any amount the member would not be responsible for if you were a participating provider.		
Please list all diagnosis, specific treatment and specific dates of treatment	Diagnosis (Including ICD10 code)	Treatment (Include related code)	Dates of Treatment (current and anticipated)

Two ways to submit this form:	**Mail:** **AmeriBen, Attn: Client Services** **PO Box 9758** **Boise, ID 83707**	**Fax:** **844-282-7824**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Transition of Care FAQs

What is transition coverage?

Transition coverage provides for a temporary bridge necessary due to changes in the Preferred Provider Organization utilized by the Emory Healthcare and Emory University Health and Welfare Plan, and a specialty provider with whom you are in an active course of treatment is not a participating provider in your new plan. Transition of Care coverage does not extend to non-participating Primary Care Physicians. Transition of Care coverage facilitates minimal disruption and permits a member in an active course of treatment to continue this treatment for a transitional period of time, without penalty, at the preferred plan benefit level.

What is an active course of treatment?

An "active course of treatment" must have begun before the Participant's effective date of coverage, and means a planned course of services by the Participant's treating provider for the diagnosed condition, starting on the date the provider first renders a service and continuing for a defined course of care, subject to the Plan's terms and medical necessity requirements.

How do I apply for Transition of Care Coverage?

You can obtain a Transition of Care form through your HR Department. Transition of Care forms must be submitted to AmeriBen within three hundred sixty-five (365) days of the enrollment period and prior to receiving services (except in an emergency) from a non-participating provider. Coverage requests can be submitted by either the non-participating provider or the member through the use of The Transition Coverage Request Form.

How will I know if AmeriBen has approved my request for Transition of Care Coverage?

Once you are Plan eligible member, you will be sent a letter after the review is complete informing you whether or not your request for coverage under the Transition of Care provision has been approved. Again, in order for claims to be paid at the preferred level during the Transition of Care process, there must be an approval from AmeriBen prior to the services being rendered.

Please submit your claim form here:

Mail:
AmeriBen ATTN: Client Services
PO Box 9758
Boise, ID 83707

Fax:
844-282-7824

Questions?

Customer Care: 844-511-1914

Medical Management: 844-593-3464

Visit: engage.ameriben.com

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AmeriBen is a separate and independent company providing medical benefits administration services on behalf of self-funded group health plans.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 9758 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf