



TRANSITION OF CARE

TO PATIENT/EMPLOYEE: Please complete all sections of this form and return it to the following address:

Harrison Electrical Worker's Trust Fund
1220 SW Morrison St Ste 300
Portland OR 97205

Transition of Care (TOC) is issued under special circumstances to allow members to continue treatment with **non-network providers** for a period of time to complete a course of treatment. Please complete this form if you or one of your dependents is currently being treated by a provider who is **not** a participating provider in the Preferred Provider network. One form must be submitted for each non-participating provider.

Unstable or serious medical problems that require a **limited course of treatment or follow-up care**, such as those listed below, may be eligible for Transition of Care benefits:

- pregnancy
- recent heart attack
- bone fractures
- newly diagnosed cancer
- joint replacement
- other acute trauma or surgery

Examples of chronic medical conditions which typically are NOT eligible for Transition of Care include:

- arthritis
- hypertension
- allergies
- diabetes
- asthma

If the treating physician is in the Preferred Provider network, do NOT complete this form.

EMPLOYEE INFORMATION

Employee's Name: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Telephone #: () _____ Work Telephone #: () _____
 Social Security #: _____ Effective Date of Coverage: _____
 Company Name: _____ Phone Number: () _____

PATIENT INFORMATION

Patient's Name: _____ Social Security # _____

Relationship to Employee: _____ Physician's Name: _____

Administered by A&I Benefit Plan Administrators, Inc.
 1220 SW Morrison St., Suite 300, Portland, OR 97205-2222
 (503) 224-0048 (800) 547-4457 Fax (503) 228-0149

TRANSITION OF CARE INFORMATION

Condition being treated: _____

How long has the doctor been treating the patient for the current condition? ___years ___months

How long is treatment expected to continue? ___years ___months

What is the nature of the treatment? _____

Was the patient hospitalized recently for this condition? ___ Yes ___No Admission Date: _____

Did the patient have surgery? ___Yes ___No What type? _____ When? _____

If pregnancy-related, list initial visit date: _____ Due Date? _____

At what hospital will you deliver? _____

Physician's/Facility's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: () _____ Specialty: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize: _____

Non-Participating Provider's Name Address

to release to my Preferred Provider Health Care Plan all information relating to past, present and future health care examinations and treatments for: _____

Brief Description of Medical Condition

This information is to be used for determining the appropriate level of benefit reimbursement for services that are provided on or after the effective date of my Health Care Plan coverage if I continue treatment with the above named provider for the above diagnosis/medical condition. I understand that Transition of Care (TOC) is subject to contractual limitations and exclusions set forth in the subscriber contract. I understand and agree that TOC does not extend the contractual benefits in any way except to provide the in-network level of benefits for a non-network provider for a temporary time period.

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature *: _____ Date: _____

* If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.