



Transition of care form

This form is for self-funded members only.

To complete this form:

- Please make sure all fields are completed. Your health care professional should complete the Care provider section.
- When the form is complete, it must be signed by the member for whom the transition of care is being requested. If the patient is a minor, a guardian's signature is required.
- You must complete and submit the form for transition of care within 60 days of the effective date of coverage.
- A separate transition of care form must be completed for each condition for which you and/or your dependents are seeking transition of care.
- Please send the completed form along with relevant medical records and information to: By mail: UMR Transition of Care, PO Box 8042, Wausau, WI 54402-8042 By fax: 877-293-4926 To submit online: (1) Sign in to **umr.com** or create your account. (2) Select **Message center** at the top of the screen. (3) Then choose **Email** and select **Compose a new message**. (4) In the **Subject line** drop-down, select **Medical – Benefits/Claims**. (5) Upload your signed Transition of Care form. (6) Select **Submit**.

After receiving your request, UMR will review and evaluate the information provided. Incomplete forms will be returned to the requestor. Completion of this form does not guarantee that a transition of care request will be granted.

Member information

New UMR member (Transition of care applicant) _____

Patient name _____ UMR member ID # _____ Date of birth / /
MM DD YYYY

Address _____ City _____ State ZIP code _____

Home/cell phone _____ Work phone _____

Employer name and group # _____ Date of enrollment in the UMR plan / /
MM DD YYYY

Member's relationship to employee:

Self Spouse Dependent Other

Authorization to release records:

I authorize all physicians and other health care professionals or facilities to provide UMR information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for transition of care benefits under the plan.

Member's signature/parent or guardian's signature if member is a minor _____ Date / /
MM DD YYYY

Care provider section

Your health care professional should complete the following information.

Name (treating physician or other health care professional) _____ National Provider Identifier (NPI) or Tax ID Number (TIN) _____ Phone _____

Address _____ City _____ State _____ ZIP code _____

Facility name _____ NPI or TIN _____ City _____ State _____

Facility phone _____ Date of last visit / / Next scheduled appointment / /
MM DD YYYY MM DD YYYY

Frequency of visits _____ Diagnosis _____ Expected length of treatment _____

If maternity, expected date of delivery / /
MM DD YYYY

Please select the service description(s) that applies:

Life-threatening condition Acute condition Transplant Inpatient/confined Upcoming surgery
Disabled/disability Terminal illness Mental health/substance use Ongoing treatment

Is the treatment for an exacerbation of a previous injury or chronic condition? Yes No

Current condition and associated treatment plan

(Include brief statement and all relevant CPT codes)

If these care needs are not associated with the condition for which you are requesting transition of care coverage, please complete a separate transition of care form for each condition.

We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered.

Please note the following for out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from us along with any copayment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of health care professional _____ Date / /
MM DD YYYY

CONFIDENTIALITY NOTICE: Information in this document is considered to be UMR's confidential and/or proprietary business information. This information may be used only by the person or entity to which it is addressed. Any recipient shall be liable for using and protecting UMR's proprietary business information from further disclosure or misuse, consistent with the recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime, and may also be subject to a civil penalty for each violation.

