GlobalHealth Transition of Care Request Form

• ***This form needs to be completed if you are currently under care utilizing a different health carrier. This is necessary, even if your current provider is also a GlobalHealth provider. Some specialists and facilities currently scheduled for your care may differ from GlobalHealth's network.*** • *Use separate form for each condition. Photocopies of this form are acceptable. Attach additional information if necessary.*

Employer	Policy #	Date of Enrollment in GlobalHealth Benefit Plan (mm/dd/yyyy)	
Employee Name		Employee Social Security #	Work Phone
Home Address Street	City	State Zip	Home Phone
Patient's Name	Patient's Soc. Sec. #	Patient's D O B (mm/dd/yyyy)	Relationship to Employee ☐ Spouse ☐ Child ☐ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? ☐ Yes ☐ No
2. If yes, when is the due date? (mm/dd/yyyy)
3. Is the patient currently receiving treatment for any acute conditions or trauma? ☐ Yes ☐ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with GlobalHealth? ☐ Yes ☐ No
5. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy, or a candidate for Organ Transplant?
6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
7. Is the patient receiving mental health/substance abuse care? ☐ Yes ☐ No
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care. Utilize space on back of page.
9. Please complete the treating physician's information below.

Group Practice Name		
Physician's Name		Telephone # of Physician
Physician's Specialty		
Address of Physician		
Name of Hospital at Which Your Physician Practices		Telephone # of Hospital
Address of Hospital		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

10. Is this patient expected to be in the hospital when coverage with GlobalHealth begins or during the next 60 days? ☐ Yes ☐ No
11. Newly selected GlobalHealth Primary Care Physician's Name

I hereby authorize the above physician(s) to provide GlobalHealth or any affiliated GLOBALHEALTH company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. This authorization will expire 24 months from the date signed. I understand I may revoke this authorization at any time by writing to the address listed at the bottom of this form. I understand that I cannot restrict information that may have already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Describe condition from #8 requiring transition of care:

INSTRUCTIONS FOR COMPLETING TRANSITION OF CARE REQUEST FORM

A separate Transition of Care Request Form must be completed for each condition for which you or your dependents are seeking Transition of Care benefits. Please make certain that all questions are answered completely. When the form has been completed, the patient for whom Transition of Care benefits have been requested should sign it. If the patient is a minor, a guardian's signature is necessary.

To help ensure a timely review of your transition case, please return the form as soon as possible. The completed forms should be marked "Confidential" and forwarded to the below address.

The first few sections of the form apply to the Employee. When the form asks for the patient's name, only the name of the person, who is actually undergoing care and is requesting Transition of Care, should be reflected.

Please send the form to:

- **GlobalHealth, Inc.**
- Customer Care Department
- P.O. Box 2328
- Oklahoma City, OK 73101-2328
- 1-405-280-5600 (phone) 1-877-280-5600 (Toll Free) 1-405-280-5240 (Fax)