GlobalHealth
Transition of Care Request Form

This form must be completed if you are currently under a different health insurance plan even if your current health care provider is also a GlobalHealth provider. Some specialists and facilities that you currently use may not be in the GlobalHealth network.

INSTRUCTIONS FOR COMPLETING TRANSITION OF CARE REQUEST FORM

A separate Transition of Care Request Form must be completed for each condition for which you are seeking Transition of Care benefits. Photocopies of this form are acceptable. Please make sure all questions are answered completely. Attach additional information if necessary. When the form has been completed, the patient for whom Transition of Care benefits have been requested, should sign it.

To help ensure timely review, please mail this form as soon as possible to the address shown on the back.

Patient's Name	Date of Birth (mm/dd/yyyy)	Social Security #
Date of Enrollment in GlobalHealth (mm/dd/yyyy)	Policy #	Home Phone #
Home Address City State Zip		Alternate Phone #

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

Treating Physician's Group Practice Name (if known)	
Physician's Name	Physician's Phone #

GlobalHealth Transition of Care Request Form (cont.)

Physician's Specialty		
Address of Physician		
Name of Hospital at Which the Physician Practices	Hospital's Phone #	
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		

8. Is the patient expected to be in the hospital when coverage with GlobalHealth begins or within the next 60 days? ☐ Yes ☐ No
9. GlobalHealth Primary Care Physician's Name

_____

Describe conditions from question #7 requiring transition of care:

I hereby authorize the above named physician(s) to provide GlobalHealth with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. The 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	Date (mm/dd/yyyy)

PLEASE SEND THIS FORM TO:

GlobalHealth
Utilization Management
P.O. Box 2840
Oklahoma City, OK 73101-2328