

Please note that this information pertains to you and/or your dependents health care and is not intended for authorization of services. If you are currently under the care of a non-network provider, there are a limited number of medical conditions that may qualify for Transition of Care. If transitional care is appropriate, specific treatment by a non-network provider may be covered at the network level of benefits for a limited period of time. These services are subject to eligibility and coverage limitations at the time the medical care is administered.

This form must be submitted within 30 days of your new enrollment date.

Please check box if this is dependent information.

Employee Name:	DOB:	Employee ID#:		
Dependent Name:	DOB:	EPO	PPO	HSA
Day Time Phone: ()		<input type="checkbox"/> Aetna	<input type="checkbox"/> Aetna	<input type="checkbox"/> Aetna
Address:		<input type="checkbox"/> BCBSAZ	<input type="checkbox"/> BCBSAZ	
		<input type="checkbox"/> UHC	<input type="checkbox"/> UHC	
		<input type="checkbox"/> Cigna		
Primary Care Physician:		Medicare Primary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Phone: ()		
Do you use any specialty injectable medication other than insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please list:				
Are you presently scheduled for/or recently receiving any of the following services? Check all that apply.				
<input type="checkbox"/> Elective Surgery	Facility: (Including transplant) Date: Nature of Surgery:	Physician Name: Phone:		
<input type="checkbox"/> Pregnancy	Due Date:	Physician Name: Phone:		
<input type="checkbox"/> Radiation Oncology	Facility: Date:	Physician Name: Phone:		
<input type="checkbox"/> Chemotherapy	Facility: Date:	Physician Name: Phone:		
<input type="checkbox"/> Dialysis	Facility: Date:	Physician Name: Phone:		
<input type="checkbox"/> Outpatient Rehabilitation	Facility: Date:	Physician Name: Phone:		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Cardiac Therapy	
<input type="checkbox"/> Home Health Services	Agency Name: (Including skilled nursing)	Nature of Services:		
<input type="checkbox"/> Durable Medical Equipment	Vendor Name:	Please check all that apply:		
		<input type="checkbox"/> Catheter supplies	<input type="checkbox"/> CPAP	<input type="checkbox"/> Bed/Mattress
		<input type="checkbox"/> Ostomy supplies	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Wheelchair
				<input type="checkbox"/> Diabetic Supplies
Do you have any of the following diseases: <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> CHF				
Do you have any health care concerns where you may need assistance from a case manager? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please explain:				
Are you currently receiving mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:				
Provider Name:	Provider Phone: ()	Date of Next Appt:		
Are you currently receiving substance abuse services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:				
Provider Name:	Provider Phone: ()	Date of Next Appt:		

Please fax this form to your designated claim carrier:

Aetna Public & Labor Segment Transition of Care 4645 E Cotton Center Blvd Bldg 1 Phoenix, AZ 85040 Fax: (860) 607-7288	Blue Cross Blue Shield of Arizona Attention Transition of Care Mail Stop A223 PO BOX 13466 Phoenix AZ 85002-3466 Fax: (602) 864-3102	Cigna Health Facilitation Care Center Attention: Transition of Care 3200 Park Lane Drive Pittsburgh, PA 15275 Fax: (412) 747-7087	UnitedHealthcare Attn: Transition of Care 1301 W. President George Bush Hwy Richardson, TX 75080 Fax: (855) 686-3561
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Confidentiality Notice: This document contains confidential information intended for a specific purpose and is protected by law.