Transition of Care Form

Personal and confidential

How to complete the form and fax it to us

Step 1: Fill out these sections:
Section 1: Group or employer information
Section 2: Subscriber and patient information
Section 3: Previously approved/authorized treatment or procedure
Section 4: Read the authorization, then sign and date the form.
Section 5: Provider Information

Step 2: **Fax** the completed form to HMA for review and follow up with your provider. You should complete one form for each health care provider.

Fax completed form to 1 (866) 293-9665

☐ Medical ☐ Mental health/substance abuse

Please indicate above whether this request is for medical treatment or mental health/substance abuse treatment.

1. Group or employer information (note: Complete a separate form for each patient and/or provider.)

Group or employer's name	Plan effective date

2. Subscriber and patient information

Subscriber's name	Birthdate (MM/DD/YYYY)
Patient's name (please print)	Telephone number
Patient's address (please print)	

3 Previously approved treatment or procedure: Please describe services that you have been scheduled to receive.

Do you have any approved future surgical procedures or hospital admissions?	☐ No ☐ Yes – Please describe services that you have been scheduled to receive.
Has your doctor prescribed any self injectable medications for you?	☐ No ☐ Yes – Please describe services that you have been scheduled to receive.
Are you currently under the care of any specialists?	☐ No ☐ Yes – Please describe services that you have been scheduled to receive.
Any other pertinent health information (for example, are you scheduled for chemotherapy treatment, radiation treatment, physical therapy, etc.)?	

4. Authorization

I request approval for coverage of ongoing care from the health care provider named below for treatment started before my effective date with HMA. If approved, I understand that the continued authorization for services will be valid for a certain period of time. I give permission for the health care provider to send any needed medical information and/or records to HMA.	
Patient's signature (**required** if patient is age 17 or older)	Date (MM/DD/YYYY)
Parent's signature (**required** if patient is age 16 or younger)	Date (MM/DD/YYYY)

5. Provider information (Note: Provide information below to avoid delay in the processing of this request.)

Name of treating doctor or other health care provider (please print)	Telephone number
First scheduled appointment after beginning HMA coverage (as applicable)	