Transition of Care Form
Personal and Confidential

Step 1: Complete ALL sections below (please print)
Step 2: Fax the completed form to HMA for review and follow up with your provider(1 (866) 293-9665)

1. Group/Employer Information

Group/Employer's Name:	Plan Effective Date:

2. Subscriber and MemberInformation

Subscriber's Name:	Member's Birthdate: (MM/DD/YYYY)
Member's Name:	Telephone Number:
Member's Address:	Email Address:

3. Previously approved treatment or procedure:

Do you have any approved future surgical procedures or hospital admissions? (Describe Services if Yes) ☐ No ☐ Yes
Has your doctor prescribed any self-injectable medications for you? (Describe Medications if Yes) ☐ No ☐ Yes
Are you currently under the care of any specialists? (List Specialist name, specialty and reason if Yes) ☐ No ☐ Yes
Any other pertinent health information: (for example, are you scheduled for chemotherapy treatment, radiation treatment, physical therapy, etc.)?

4.Authorization

I request authorization (if required) 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 hereby give my permission for the health care provider to provide any necessary medical information and/or records to HMA to ensure authorization of the requested services.	
Member's signature: (**required** if patient is age 17 or older)	**Date** (MM/DD/YYYY)
Parent/Guardian signature: (**required** if patient is age 16 or younger)	**Date** (MM/DD/YYYY)

5.Provider information (Note: Provide information below for each provider/service to avoid delay in the processing of this request)

Provider 1: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 2: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 3: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 4: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 5: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 6: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 7: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 8: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 9: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage:

Provider 10: Name of treating doctor or other health care provider:	Telephone number:
Services to be received from this provider:	First scheduled appointment after beginning HMA coverage: