Transition of Care Request

SANFORD HEALTH PLAN

Application Instructions

Follow the steps below to find out if you should complete this form for you, a spouse, or any covered dependents.

STEP 1

Make sure that your health care provider is in Sanford Health Plan's network.
You can check this two ways:

1. Look for your provider under **Find a Doctor** at **sanfordhealthplan.com**
2. Call Customer Service toll free at **(800) 752-5863 | TTY: 711**

Check the box below that applies to you:

☐ Yes, the provider I want to continue seeing is in the Sanford Health Plan network.
STOP! You do not need to fill out this form.

☐ No, the provider I want to continue seeing is NOT in the Sanford Health Plan network.
GO to Step 2.

STEP 2

AND you would like to continue care with this provider because you (or other covered member) have one of the medical or behavioral conditions below:

1. In the 2nd or 3rd trimester of pregnancy
2. A surgery which is already planned
3. Receiving cancer treatments
4. Receiving transplant services
5. Receiving services where it would be deemed harmful to transition at this point of treatment
6. A life threatening mental or physical illness
7. A physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for a least one year, or can be expected to result in death
8. A physician's certification that there is an expected lifetime of 180 days or less

Check the box below that applies to you:

☐ Yes, I (or other covered member) am affected by one of the conditions listed above.
GO to Step 3.

☐ No, I am not affected by one of the conditions listed above.
STOP! You do not need to fill out this form. (Not eligible for Transition of Care consideration.)

STEP 3

This form must be completed within 90 days of your plan's effective date or within 90 days of your provider terminating with the Sanford Health Plan network.

Return this form via mail or fax to:

Sanford Health Plan
Attn: Transition of Care
PO Box 91110
Sioux Falls, SD 57109
Fax: (605) 312-8910

Medical records may be requested to fully review your case for a Transition of Care.
You will receive a letter notifying you whether the request is approved.

Transition of Care Request

SANFORD HEALTH PLAN

☐ New enrollee to Sanford Health Plan ☐ Existing member whose provider terminated from your plan's network

Employer	Group #	Employee date of enrollment in plan
Subscriber name	Sanford Health Plan member ID	Work phone
Home address (including City, State and Zip)		Home/mobile phone
Patient's name	Patient's social security # or alternate ID / Patient's date of birth	Relationship to employee ☐ Spouse ☐ Dependent ☐ Self

Is the patient pregnant and in the 2nd or 3rd trimester of pregnancy? ☐ Yes ☐ No
Due date: _____ (mm/dd/yyyy)

If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. ☐ Yes ☐ No

Is the patient scheduled for surgery or hospitalization after your effective date with Sanford Health Plan? ☐ Yes ☐ No

Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ☐ Yes ☐ No

Is the patient receiving transplant services? ☐ Yes ☐ No

Is the patient receiving services where it would be deemed harmful to transition at this point of treatment? ☐ Yes ☐ No

Is the patient receiving treatment for a life threatening mental or physical illness? ☐ Yes ☐ No

Do you have any cultural needs to be considered during your transition of care? ☐ Yes ☐ No

If you answered **YES** to any of the above questions, please describe the condition for which the patient requests Transition of Care in the section below or attach it on a separate piece of paper.

Clinic or group practice name	
Health care provider name and specialty	Health care provider phone #
Health care provider address	
Hospital where health care provider practices	Hospital phone #
Hospital address	
Type of surgery (if applicable)	Date of surgery (if applicable) (mm/dd/yyyy)
Reason for treatment or diagnosis	
Treatment being received and expected duration	

When did this condition begin (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Frequency of visits (if applicable)

I understand that submission of this form does not guarantee authorization or payment for the requested services. I certify and attest that, I am the above-referenced Patient and submit this form on my own behalf (or am such Patient's guardian and submit this form on the patient's behalf; and to the best of my knowledge, information, and belief, I have provided true and correct responses to all questions. I hereby authorize the above health care provider to give Sanford Health Plan or its affiliates and contracted parties' any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)