Transition of Care Request

We understand transition can cause uncertainty. We're here to help.

Complete this request if:

Your employer has contracted with Sanford Health Plan and you have not yet enrolled or are within 30 days of when your health insurance became effective and a provider you currently see is not in the network.

Questions?
Contact your Welcome Team
(800) 843-8583

-OR-

You currently have Sanford Health Plan insurance and have been notified in the last 30 days a provider will no longer be in the network for your chosen plan.

Questions?
Contact the Customer Service Number on your ID card

And, you would like care to be continued by this provider for you, a spouse, or a dependent who is/has:

a. in the 2nd or 3rd trimester of pregnancy
b. a surgery which is already planned
c. receiving cancer treatment
d. receiving transplant services
e. receiving services where it would be deemed harmful to transition at this point of treatment
f. a life threatening mental or physical illness
g. 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
h. a physician's certification that there is an expected lifetime of 180 days or less (pursuant to Minnesota Statute 62Q.56)

This form should not be completed if you, a spouse, or dependent would like to continue with a provider who does not participate with Sanford Health Plan for yearly physicals and/or routine medical care. Our teams listed above can help match you with a provider for these needs.

If you meet the above criteria, please follow the steps below to have your request considered:

1. ***Complete*** the attached Transition of Care Request Form in its entirety. Our team will personally review your request so it is important to have clear, complete information to review. Feel free to type in the form or attach a second page to the form if needed.
2. ***Sign*** the form.
3. ***Send*** the form to Sanford Health Plan:
   - Mail: PO Box 91110, Sioux Falls, SD 57109
   - Fax: (605) 328-6812
   - Complete online: **sanfordhealthplan.com/transition-of-care**

A letter explaining the outcome of your request will be mailed to you within 10 business days from when we receive your request.

TTY/TDD: (877) 652-1844. For free help in a language other than English, call (800) 892-0675.

SANFORD HEALTH PLAN

Transition of Care Request

SANFORD HEALTH PLAN

Please Note: Print clearly or type requested information. Use a separate form for each condition. Please attach any additional information or documentation you wish considered to this request. **Completion of this form does not guarantee authorization or payment for the requested services.**

Employer of Policyholder: ______________________________

Employee or Policyholder Name: ____________________ Member ID (if current member): ____________________

Date of Birth: ______________________________

Address: ______________________________ City/State: ____________________ Zip: __________

Home Phone Number: ____________________ Work Phone Number: ____________________

Patient's Name: ______________________________ Date of Birth: ____________________

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent Child

Describe health condition: ______________________________

____

____

When did condition begin? ______________________________

Out-of-Network Facility Requested for In-Network Benefits: ______________________________

Facility Location: ______________________________

Physician(s) currently involved (list names): ______________________________

____

Address: ______________________________ City/State: ____________________ Zip: __________

Date of last visit: ____________________ Frequency of visits: ____________________

Describe current treatment or proposed surgery or treatment: ______________________________

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Expected length of treatment or date of surgery: ______________________________

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Primary care physician name: ______________________________

Physician's Address: ______________________________ City/State: ____________________ Zip: __________

Do you have any cultural needs that need to be considered during your transition of care? ____________________

If yes, please explain: ______________________________

Please read and sign:

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.

____

Signature of Patient or Guardian Date Signed

Completing this form does not guarantee authorization or payment for the requested services. Please review this form in its entirety.