

# *Transition of Care*



CIGNA®

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# Your CIGNA HealthCare of California Transition of Care Benefits

## Transition of Care benefits are intended to provide coverage for individuals who meet all of the following criteria:

- 1) They have one of several specified medical conditions.
- 2) They require ongoing treatment for a certain period of time.
- 3) They are receiving services from doctors, other health professionals, hospitals or other facilities that are not part of their network (non-participating). Individuals assigned to a Primary Care Physician (PCP) who is affiliated with a medical group receive care from doctors and other health care professionals and facilities contracted with the medical group.
- 4) They are receiving these services at the time they become eligible for a CIGNA plan.

## How it Works

- You should apply for Transition of Care benefits at the time of enrollment, but must apply no later than the first 30 days after the effective date of coverage.
- You must already be receiving care for a qualifying medical condition by the health care professional identified on the Transition of Care Request Form.
- If you meet the requirements for Transition of Care benefits, CIGNA will contact the health care professional. If the health care professional agrees to CIGNA's contractual terms and conditions, you will receive the in-network level of benefits for treatment of the specific condition for either a specific amount of time or as long as the condition exists. If the health care professional does not agree to CIGNA's contractual terms and conditions, CIGNA may deny or only provide limited Transition of Care benefits. You will also be notified about the decision within 30 days of your request, or sooner if our clinical reviewers determine the request should be expedited based on your condition.
- Approved benefits only apply to the treatment provided or ordered by the doctor identified on the Transition of Care Request Form for the medical condition specified on the form.
- Claims for treatment of the specific condition by the approved doctor and/or facility after the effective date of coverage will be considered at in-network levels.
- The availability of Transition of Care benefits does not mean a treatment is covered, nor does it constitute pre-authorization of medical services to be provided. Benefit determinations and pre-authorizations must still be obtained during the pre-certification and case management process.
- All benefits are subject to the provisions of the plan.
- **You will be responsible for the cost of any services provided by any non-participating health care professional hospital or other facility unless they are approved by CIGNA for Transition of Care benefits. Individuals assigned to a Primary Care Physician (PCP) who is affiliated with a medical group receive care from doctors and other health care professionals and facilities contracted with the medical group.**

## Medical conditions and other situations that may qualify for Transition of Care benefits include:

- An acute condition, for the length of the acute condition. An "acute condition" is defined as a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.
- A serious chronic condition, for a period needed to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by CIGNA in consultation with the enrollee and treating health care professional, consistent with good professional practice. This period shall not exceed 12 months from the effective date of coverage for the newly covered enrollee. A "serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and:
  - persists without full cure;
  - worsens over an extended period of time; or
  - requires ongoing treatment to maintain remission or prevent deterioration.
- A pregnancy, for the length of the pregnancy (three trimesters) and the immediate postpartum period.
- A terminal illness, for the length of the terminal illness. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less.
- Care of a newborn child whose age is between birth and age 36 months, regardless of whether the child is undergoing an active course of treatment, for a period not to exceed 12 months.
- Performance of surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment that is to occur within 180 days of the effective date of coverage.

## If I am approved for Transition of Care benefits for one illness, can I receive in-network benefit payments for a non-related condition?

In-network benefit levels provided as part of Transition of Care benefits are for the specific illness/condition only and cannot be applied to another illness/condition. You must complete a Transition of Care Request Form for each unrelated illness/condition no later than 30 days after coverage becomes effective.

## Do I need to complete the Transition of Care Request Form if I am already seeing a participating health care professional?

No, if you are receiving care from a doctor in the CIGNA network, or assigned to a PCP who is affiliated with a medical group and receive care from doctors or other health care professionals and facilities contracted with the medical group, you do not need to request Transition of Care. Check the CIGNA HealthCare directory or [www.cigna.com](http://www.cigna.com) to verify that your doctor is in the network.

See instructions for completing this form on the reverse side.



# CIGNA Transition of Care Request Form

**\*\*\*ATTENTION: You may not need to complete this form\*\*\***

- **Complete this form only if you are utilizing a non-participating health care professional. Please check your CIGNA directory or check the CIGNA website ([www.cigna.com](http://www.cigna.com)) to verify that your doctor is in your network.**
- See reverse for instructions to complete this Transition of Care Request Form.
- Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

Employer		Policy #		Employee Date of Enrollment in CIGNA Benefit Plan(mm/dd/yyyy)	
Employee Name			Employee Social Security #		Work Phone
Home Address	Street	City	State	Zip	Home Phone
Patient's Name		Patient's Social Security #		Patient's Birthdate (mm/dd/yyyy)	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Self

- Is the patient pregnant?  Yes  No
- If yes, when is the due date? \_\_\_\_\_ (mm/dd/yyyy)  Yes  No
- Is the patient currently receiving treatment for an acute condition or trauma?  Yes  No
- Is the patient scheduled for surgery or hospitalization after your effective date with CIGNA?  Yes  No
- Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate for Organ Transplant?  Yes  No
- Is the patient receiving treatment as a result of a recent major surgery?  Yes  No
- Is the patient receiving mental health/substance abuse care?  Yes  No
- Is the patient receiving care for a terminal illness?  Yes  No
- If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care.

10. Please complete the information below.

Group Practice Name		
Doctor's Name		Telephone # of Provider
Doctor's Specialty		
Doctor's Address		
Hospital Where Patient's Doctor Practices		Telephone # of Hospital
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

- Is this patient expected to be in the hospital when or after coverage with CIGNA begins?  Yes  No
- Please list any other continuing care needs that may qualify for Transition of Care benefits. If these needs are not related to the condition for which you are applying for Continuity of Care benefits, you must complete a separate Transition of Care Form.

I hereby authorize the above physician to provide CIGNA HealthCare or any affiliated CIGNA company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under CIGNA HealthCare. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)
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# Instructions for Completing the Transition of Care Request Form

- You must complete a separate Transition of Care Request Form for each condition for which you or your dependents seek Transition of Care benefits. Additional forms are available through the CIGNA HealthCare of California website, [www.cigna.com/customer\\_care/member/forms](http://www.cigna.com/customer_care/member/forms). You may use photocopies.
- Please answer all questions completely.
- Completed forms should be signed by the patient for whom Transition of Care benefits have been requested. If the patient is a minor, a guardian must sign the form.
- To help ensure a timely review of your case, please return the form as soon as possible. **You must apply for Transition of Care benefits within the first 30 days** after the effective date of coverage. Completed forms should be marked "Confidential" and forwarded to the address below.

## Important Notes

**Questions 1-6:** If you answered "Yes" to any of these questions, or if you are submitting this Transition of Care Request Form for any other non-mental health care services, please send the form to:

CIGNA Health Facilitation Care Center      FAX (800) 558-3710  
400 N. Brand Blvd., Suite 400  
Glendale, CA 91203

**Question 7:** If you answered "Yes" and are receiving **mental health/substance abuse services**, and your plan includes mental health/substance abuse coverage through CIGNA Behavioral Health of California, please forward this form to:

CIGNA Behavioral Health      FAX (818) 551-2722  
450 N. Brand Blvd., Suite 500  
Glendale, CA 91203

**Question 8:** Please include information about your current or proposed treatment plan and how long your treatment is expected to continue. If surgery has been planned, state the type and the proposed date of your surgery.

**Question 12:** Briefly state the health condition. When did it begin and what doctor is currently involved? How often do you see this doctor? Be as specific as possible.



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