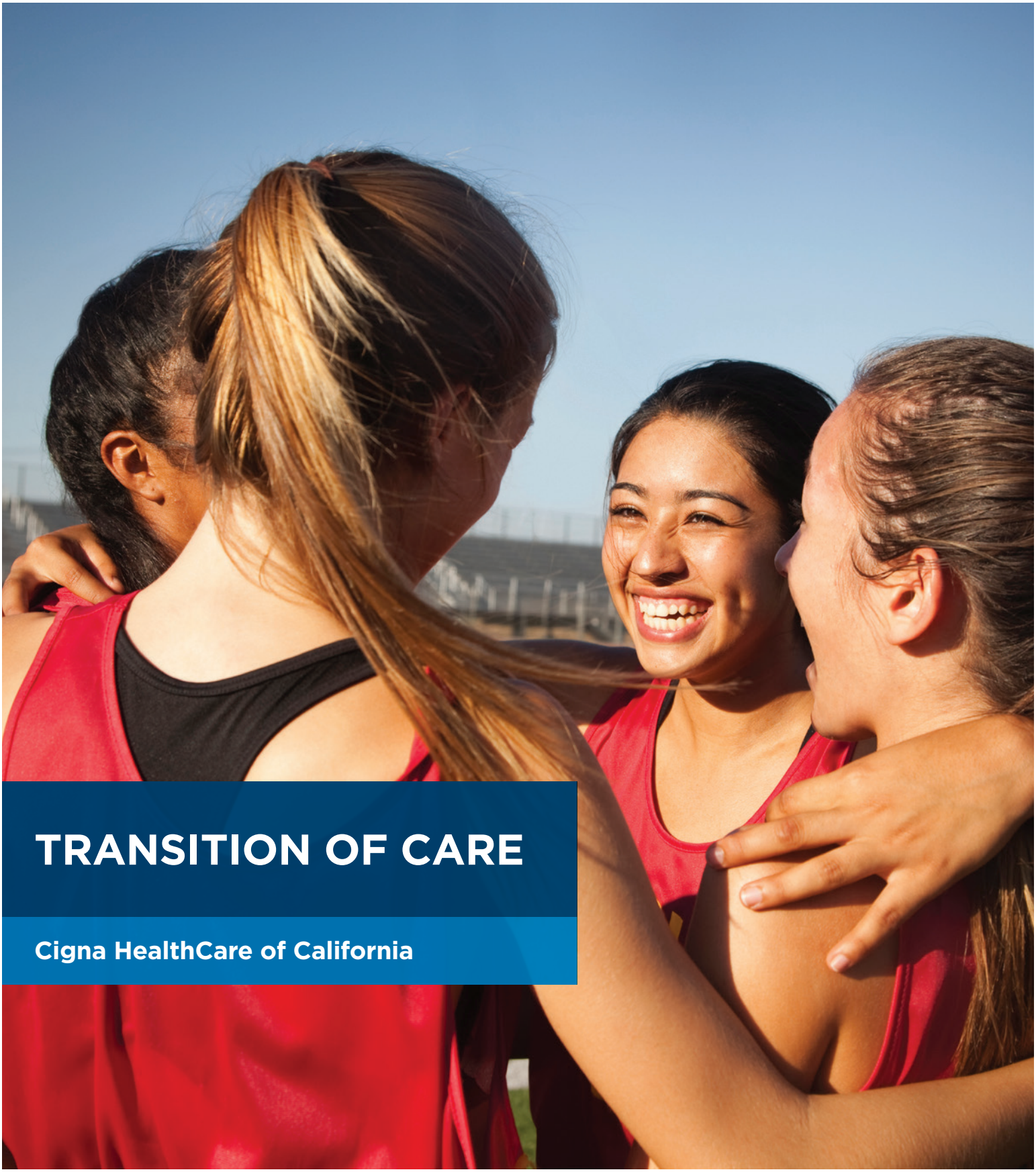

TRANSITION OF CARE

Cigna HealthCare of California

Cigna®

593689 n CA 12/22

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, hospitals, facilities or other health care providers that are not part of the network included with their new plan (non-participating).
4) They are receiving these services at the time they become eligible for a plan.

How it works

- You should apply for Transition of Care benefits as soon as possible, and preferably between 30–60 days after the effective date of coverage.
- You must already be receiving care for a qualifying medical condition by the health care provider identified on the Transition of Care Request Form.
- If you meet the requirements for Transition of Care benefits, We will contact the health care provider. If the provider agrees to our 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 depending on the situation. If the health care provider does not agree to our contractual terms and conditions, we 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 we determine the request should be expedited based on your condition.
- Approved benefits only apply to the treatment provided or ordered by the provider 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 provider 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 preauthorization of medical services to be provided. Benefit determinations and preauthorizations must still be obtained during the precertification and case management process.
- All benefits are subject to the provisions of the plan.
- **If you do not have out-of-network coverage on your plan you will be responsible for the cost of any services provided by any non-participating health care provider, hospital or other facility unless they are approved by Cigna for Transition of Care benefits.**

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 us in consultation with the enrollee and treating health care provider, consistent with good provider 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.

Do I need to complete the Transition of Care Request Form if I am already seeing a provider in my plan's network?

No, if you are receiving care from a provider in the network included with your new plan, you do not need to request Transition of Care. To verify if a provider is in your plan's network, view the directory, or go to **Cigna.com** and click on "Find a doctor." You can also call the number on your ID card and speak with a Customer Service specialist for assistance.

No Cost Language Services for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-244-6224 for medical/dental or 1-866-421-8629 for mental health/substance use. For more help, call either the HMO Help Center at 1-888-466-2219 or for Non-HMO plans (e.g. PPO) call the CA Dept. of Insurance at 1-800-927-4357. **English**

Servicios de idioma sin costo para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-244-6224 para servicios médicos/dentales de o al 1-866-421-8629 para la salud mental/consumo de sustancias. Para obtener ayuda adicional, llame al Centro de ayuda HMO al 1-888-466-2219 o para los planes que no sean HMO (p. ej. PPO) llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得**免費語言服務**。您可取得口譯員服務。我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-244-6224 與醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 行爲健康服務的精神健康 / 物質使用部門。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電 1-800-927-4357 與加州保險部聯絡。**Chinese**

خدمات لغوية بدون تكلفة للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأمين صادرة في ولاية كاليفورنيا. يُمكنك الاستعانة بمترجم. يمكنك طلب قراءة الوثائق لك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-244-6244 للحصول على الخدمات الطبية / خدمات طب الفم والأسنان أو على الرقم 1-866-421-8629 للصحة النفسية / تعاطي المواد المخدرة. وللحصول على المزيد من المساعدة، اتصل إما بمركز HMO للمساعدة على الرقم 1-888-466-2219 أو للبرامج الأخرى غير HMO (مثل PPO)، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. **Arabic**

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 **무료 언어 지원 서비스**. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 의료/치과 안내번호(1-800-244-6224번), 혹은 정신 건강/약물 사용에 대해서는 안내번호(1-866-421-8629번)로 연락해주십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나 비-HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주 보험국(CA Dept. of Insurance) 안내번호 1-800-927-4357번으로 연락해주십시오. **Korean**

Walang Gastos na Mga Serbisyo sa Wika para sa mga customer na nakatira sa California at mga customer na nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-244-6224 para sa medikal/dental o sa 1-866-421-8629 para sa mga kalusugang pangkaisipan/paggamit ng droga. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

Dịch vụ trợ giúp ngôn ngữ miễn phí cho khách hàng sinh sống trong tiểu bang California và khách hàng sống ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi chương bảo hiểm y tế/nha khoa theo số 1-800-244-6224, hoặc gọi số 1-866-421-8629 để biết thông tin về chương trình chăm sóc sức khỏe tâm thần/sử dụng chất gây nghiện. Để được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình PPO). **Vietnamese**

សេវាបកប្រែភាសាដោយឥតអស់ថ្លៃ សម្រាប់អតិថិជនដែលរស់នៅក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា និងអតិថិជនដែលរស់នៅក្រៅរដ្ឋកាលីហ្វ័រនីញ៉ា ដែលបានគ្រប់គ្រង នៅក្រោមច្បាប់សន្យា បានចេញឱ្យក្នុងរដ្ឋកាលីហ្វ័រនីញ៉ា។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឱ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឱ្យអ្នក ជាភាសាខ្មែរ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬលេខ 1-800-244-6224 សម្រាប់ខាងសុខភាព/ធ្មេញ ឬ 1-866-421-8629 សម្រាប់ខាងឥរិយាបថសុខភាពអារម្មណ៍/ ការរំលោភសារធាតុញៀន ។ សម្រាប់ជំនួយថែមទៀត ទូរស័ព្ទទៅមជ្ឈមណ្ឌលជំនួយ HMO តាមលេខ 1-888-466-2219 ឬសម្រាប់គម្រោងមែនមែនជា HMO (ដូចជា PPO) ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។**Khmer**

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਤੋਂ ਬਾਹਰ ਰਹਿੰਦੇ ਹਨ ਅਤੇ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਲਿਸੀ ਦੇ ਅਧੀਨ ਕਵਰਡ ਹਨ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਸਾਨੂੰ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਉੱਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਜਾਂ ਮੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-244-6224 ਤੇ ਜਾਂ ਮਾਨਸਿਕ ਸਿਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਮਦਦ ਕੇਂਦਰ ਨੂੰ 1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾਵਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਮਾ ਵਿਭਾਗ (CA Dept.of Insurance) ਨੂੰ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

خدمات رایگان مربوط به زبان برای مشتریانی که در کالیفرنیا زندگی می‌کنند و مشتریانی که در خارج کالیفرنیا زندگی کرده و بر اساس بیمه نامه‌ای که در کالیفرنیا صادر شده تحت پوشش هستند. می‌توانید از خدمات یک مترجم شفاهی برخوردار شوید. می‌توانید بگوئید که مدارک به زبان شما برایتان خوانده شوند و برخی از آن‌ها به زبان شما برایتان ارسال شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است تماس بگیرید و یا با شماره 1-800-244-6224 برای طرح پزشکی/دندانپزشکی یا با شماره 1-866-421-8629 برای برنامه بهداشت روانی/مصرف مواد مخدر تماس بگیرید. برای دریافت کمک بیشتر، با مرکز کمک HMO به شماره 1-866-466-2219 و یا برای طرح‌های غیر HMO (برای مثال PPO) به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. **Persian**

無料の言語サービス。カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まいで、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカードに記載の電話番号、または医療・歯科サービス担当：1-800-244-6224、またはメンタルヘルス・薬物使用のための担当：1-866-421-8629までご連絡ください。その他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。**Japanese**

Бесплатные услуги перевода для клиентов, проживающих на территории штата Калифорния, а также для тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши документы, а также выслать перевод некоторых из них на вашем языке. Чтобы получить помощь, позвоните нам по номеру, указанному в вашей идентификационной карте; по вопросам получения медицинских/стоматологических услуг, позвоните по номеру 1-800-244-6224, по вопросам психического здоровья/употребления наркотиков — 1-866-421-8629. Для получения дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону 1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

Անվճար Լեզվական Ծառայություններ անդամների համար, ովքեր բնակվում են Կալիֆորնիայում և անդամների համար, ովքեր բնակվում են Կալիֆորնիայից դուրս բայց ապահովագրված են Կալիֆորնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով: Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ՝ 1-800-244-6244, բժշկական/ատամնաբուժական ծրագրի համար կամ՝ 1-866-421-8629 վարքային առողջապահական ծառայությունների համար՝ հոգեկան առողջության/թմրանյութերի օգտագործման դեպքում: Լրացուցիչ օգնության համար զանգահարեք կա՛մ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ՝ Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք 1-800-927-4357 համարով: **Armenian**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi rau cov qhua uas nyob hauv xeev California thiab cov qhua uas nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus. Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-244-6224 rau chaw pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau thov kev pab cuam kev noj qab haus huv fab kev coj cwj pwm los ntawm rau kev coj cwj pwm/kev siv yeeb tshuaj. Yog xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Muab Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. **Hmong**

कैलिफ़ोर्निया और कैलिफ़ोर्निया के बाहर रहने वाले कैलिफ़ोर्निया में जारी पॉलिसी के तहत कवर किये गए ग्राहकों के लिए **निःशुल्क भाषा सेवाएं**। आप एक दुभाषिया प्राप्त कर सकते हैं। आप इन दस्तावेज़ों को किसी से पढ़वा सकते हैं और कुछ दस्तावेज़ों को अपनी भाषा में प्राप्त कर सकते हैं। सहायता के लिए, अपने ID कार्ड पर सूचीबद्ध नंबर पर या चिकित्सीय/दंत के लिए 1-800-244-6224 पर या मानसिक स्वास्थ्य/नशे के उपयोग संबंधी सहायता के लिए 1-866-421-8629 पर कॉल करें। अधिक सहायता के लिए, HMO सहायता केंद्र पर 1-888-466-2219 पर कॉल करें या गैर-HMO योजनाओं (उदा. PPO) के लिए 1-800-927-4357 पर CA बीमा विभाग (CA Dept. of Insurance) को कॉल करें। **Hindi**

บริการภาษาโดยไม่เสียค่าใช้จ่าย สำหรับลูกค้าที่อาศัยอยู่ในรัฐแคลิฟอร์เนีย และที่อาศัยอยู่นอกรัฐแคลิฟอร์เนียที่ได้รับการคุ้มครองภายใต้กรมธรรม์ที่ออกในรัฐแคลิฟอร์เนีย คุณสามารถขอล่ามแปลภาษาได้ คุณสามารถขอให้อ่านเอกสารให้คุณฟัง และขอให้ส่งเอกสารบางส่วนถึงคุณเป็นภาษาของคุณ หากต้องการความช่วยเหลือ โปรดโทรศัพท์ถึงเราตามหมายเลขที่ระบุไว้บนบัตรประจำตัวของคุณ หรือหมายเลข 1-800-244-6224 สำหรับบริการของ ด้านการรักษาพยาบาล/ทันตกรรมของ หรือ 1-866-421-8629 สำหรับบริการของ ด้านสุขภาพจิต/การใช้สารที่มีผลต่อจิตประสาทในทางที่ผิ หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ช่วยเหลือสำหรับแผนการรักษาพยาบาลแบบ HMO ที่หมายเลข 1-888-466-2219 หรือสำหรับแผนการรักษาพยาบาลที่ไม่ใช่ HMO (เช่น PPO) โปรดโทรศัพท์ถึง Dept. of Insurance ของรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 **Thai**

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See instructions for completing this form on the reverse side.

Transition of Care Request Form

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

- **Complete this form only if you are receiving care from a health care provider that does not participate in your plan's network. Please check your directory or go to Cigna.com and click on "Find a doctor" to verify that your provider is in your plan's network. You can also call the number on your ID card and speak with a Customer Service specialist for assistance.**
- Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

Employer	Policy #	Employee date of enrollment (mm/dd/yyyy)
Employee name	Member ID #	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 ❑ Spouse ❑ Dependent ❑ Self

1. Is the patient pregnant? ❑ Yes ❑ No
2. If yes, when is the due date? _____ (mm/dd/yyyy)
3. Is the request for an infusion or injection medication? ❑ Yes ❑ No
   If yes, list the name of the infusion or injection drug _____
4. Is the patient currently receiving treatment for an acute condition or trauma? ❑ Yes ❑ No
5. Is the patient scheduled for surgery or hospitalization after your effective date with us? ❑ Yes ❑ No
6. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or a candidate for organ transplant? ❑ Yes ❑ No
7. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ❑ No
8. Is the patient receiving mental health/substance use care? ❑ Yes ❑ No
9. Is the patient receiving care for a terminal illness? ❑ Yes ❑ No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care.

    _____

11. Please complete the information below.

Group practice name		
Provider's name	Telephone # of provider	
Provider's specialty		
Provider's address		
Hospital where patient's provider 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		

12. Is this patient expected to be in the hospital when or after coverage with us begins? ❑ Yes ❑ No
13. 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 Request Form.

    _____

I hereby authorize the above provider to provide Cigna HealthCare of California, Inc. or its affiliates and contracted parties with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care benefits under my Cigna plan. I understand I am entitled to a copy of this authorization form.	
Signature of patient, parent or guardian	Date (mm/dd/yyyy)

▼Detach Transition of Care Request Form here.▼

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 at, **Cigna.com/customer-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 should apply for Transition of Care benefits as soon as possible, and preferably between 30–60 days, after the effective date of coverage**. Completed forms should be marked "Confidential" and forwarded to the appropriate address below. See Important Notes.

Important Notes

Questions 1–7: 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
400 N. Brand Blvd., Suite 400
Glendale, CA 91203
FAX (800) 558-3710

Question 8: If you answered "Yes" and are receiving **mental health/substance use services**, and your plan includes mental health/substance use coverage through Evernorth Behavioral Health of California, please forward this form to:

Evernorth Behavioral Health
400 N. Brand Blvd., Suite 400
Glendale, CA 91203
FAX (860) 697-7985

Question 9: 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 13: Briefly state the health condition. When did it begin and what provider is currently involved? How often do you see this provider? Be as specific as possible.

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