

Transition of Care/Continuity of Care Request Form



CLEAR FORM

This form should be used to request Transition of Care (TOC) or Continuity of Care (COC) for behavioral health conditions. It can be completed by the patient, their parent/guardian, or their health care provider and requires a patient signature.

INSTRUCTIONS AND ADDITIONAL INFORMATION

- Use this form to submit a request for TOC/COC of mental health or substance use disorder outpatient therapy, medication management, transcranial stimulation (TMS), applied behavior analysis (ABA), partial hospitalization (PHP) and intensive outpatient program (IOP). For inpatient (IP) and residential (RES), please call 800.926.2273.
- A separate TOC/COC request form must be completed for each service. Adult dependents must submit their own request or have a Release of Information on file to permit the parent/guardian to access services.
- Claims will be paid at the in-network level for the TOC/COC period only. TOC/COC requests for each family member should be submitted separately.
- Supporting clinical may be required with the completed form.
- For a network exception request outside of TOC/COC, please visit our [Behavioral Health Forms](#) center and submit the appropriate network exception request form based on the type of service.
- Approval of TOC/COC does not change the provider’s network status. If interested in becoming a participating Evernorth Behavioral Health provider, please refer to [Credentialing](#) for more information.
- For additional information, providers should review the [TOC/COC frequently asked questions flyer](#).

Please complete form and submit:

- **By mail:**
Evernorth Behavioral Health
Attn: Outpatient Clinical Support Team
6625 West 78th Street, Suite 100, Bloomington, MN 55439
- **By fax:** 844.271.1507 (Preferred)

ALL FIELDS ARE REQUIRED

Please check the appropriate box: <input type="checkbox"/> Patient is a new enrollee in the network (TOC applicant) <input type="checkbox"/> Patient whose health care provider terminated (COC applicant) <input type="checkbox"/> Patient has been notified by employer that they may qualify for COC (COC applicant)		
Employer and patient information		
Date of enrollment in plan (mm/dd/yyyy)	Member ID	
Home address		City/ state
ZIP code	Home phone/mobile	Work phone
Patient name		
Patient’s date of birth (mm/dd/yyyy)	Patient social security number (last 4 digits) or alternative ID	

Please answer yes or no for the following questions:

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| 1. Is the patient currently receiving routine outpatient therapy? | Yes | No |
| 2. Is the patient currently receiving medication management services? | Yes | No |
| 3. Is the patient currently receiving ABA services? | Yes | No |
| 4. Is the patient currently receiving TMS? | Yes | No |
| 5. Is the patient currently receiving IOP services? | Yes | No |
| 6. Is the patient currently receiving PHP services? | Yes | No |
| 7. Is the treatment for maternal mental health? | Yes | No |
| 8. Is the treatment for terminal illness? | Yes | No |
| 9. For COC, did you receive notification that your provider will no longer be in the Cigna Healthcare network?
If yes, please provide date on letter | Yes | No |
| 10. If you did not answer "yes" to any of the above questions, please describe the condition for which the patient requests TOC/COC. | | |

Health care provider information

Group practice name (if applicable)		Provider name	
Provider Tax payer Identification Number (TIN)		Provider phone number	
Provider license type		Provider license number	
Service location address		City/state	ZIP code
If ABA, practice address		If ABA, practice phone number	
Diagnostic codes			
Outpatient Current Procedural Terminology (CPT®) codes			
Treatment start date (mm/dd/yyyy)		Requested authorization start date (mm/dd/yyyy)	

Evernorth Behavioral Health or its affiliates and contracted parties are hereby authorized access to any and all information and medical records necessary to make an informed decision concerning my request for TOC/COC. It is understood that the patient is entitled to a copy of this authorization request form.

Signature of patient, parent, or guardian	Date (mm/dd/yyyy)
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