Transition of Care Benefits Application

If you have just joined MVP and you, or your covered spouse or dependent, are currently under the care of a physician who is not participating with MVP, and are undergoing treatment for a life threatening, degenerative, or disabling condition, you may be eligible for 60 days of Transition of Care Benefits with your non-MVP physician (90 days for Federal Employee Health Benefits program). If you are in your second or third trimester of pregnancy, the transitional period includes delivery and postpartum care related to the delivery.

If you, or your covered spouse or dependent, are a current MVP member and your physician has left the MVP network, and you are receiving an active course of treatment, you may be eligible for 90 days of transitional care from the date your physician leaves the MVP network. If you are in your second or third trimester of pregnancy, the transitional period includes delivery and postpartum care related to the delivery.

To be eligible for Transition of Care Benefits, you must be enrolled in a benefit plan administered by MVP. To apply, you should complete Sections 1 and 2 of this application. Ask your current non-MVP participating Physician to complete Section 3 and provide copies of relevant medical records. If there is more than one non-MVP participating physician involved in your case, please provide a separate form for each physician. You or your non-MVP participating physician(s) should send the completed application and medical records to MVP, at the address on page 2.

If MVP's Medical Director determines transitional care is medically necessary under the terms of the benefit plan, MVP will approve specific treatment, by specified non-MVP participating physician(s) for a specific period of time. It is also necessary for the non-MVP physician to agree to: 1) accept MVP's payment in full; 2) provide MVP with medical information about your care; and 3) follow MVP's policies and procedures. These services are subject to eligibility and coverage limitations at the time medical care is administered. Please refer to your Member Handbook for further details.

Section 1: Member Information *(To be completed by member applying for transition of care benefits)*

MVP Subscriber Name | MVP Subscriber No.

Street Address | City | State | Zip Code

Home Phone No. ( ) | Work Phone No. ( )

Employer Name | Plan Effective Date

Member Name | Member's Date of Birth

Relationship to Subscriber
☐ Self ☐ Spouse ☐ Dependent

Are you currently covered by:
Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No Other Insurance? ☐ Yes ☐ No

Section 2: Treatment/Care Information *(To be completed by member applying for transition of care benefits)*

Is the member currently pregnant and in the second or third trimester?	☐ Yes	☐ No
Is the member currently undergoing a course of treatment?	☐ Yes	☐ No
Is the member currently undergoing treatment for cancer?	☐ Yes	☐ No
Is the member undergoing treatment for a fracture?	☐ Yes	☐ No
Has the member been hospitalized within the past six weeks?	☐ Yes	☐ No
Has the member had surgery within the past six weeks?	☐ Yes	☐ No
Does the member have an appointment with the doctor prior to the effective date of coverage or within 30 days after?	☐ Yes	☐ No

If you answered ***Yes*** to any of the questions in **Section 2**, please have your non-MVP participating physician complete the rest of this form and return it with any pertinent medical records to MVP at the address on page 2.

If you answered ***No*** to all of the questions in **Section 2**, please contact the MVP Customer Care Center at **1-888-687-6277** for assistance identifying an MVP network physician for an evaluation.

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Subscriber Name	*MVP Subscriber No.*

Member's Authorization to Release Records

I authorize all physicians and other medical professionals or institutions to provide information to MVP Health Care® concerning medical care, advice, treatment, or supplies for the MVP Member named above. This information will be used to determine the Member's eligibility for Transition of Care benefits under the new plan.

Member's Signature, or Parent or Guardian's Signature if Member is a Minor *Date*

Section 3: Physician and Treatment/Care Information *(To be completed by treating physician)*

Non-MVP Participating Physician Name	Tax ID No.	Phone No. ( )

Street Address	City	State	Zip Code

Date of Member's Last Visit	Date of Next Scheduled Appointment	Visit Frequency	Expected Length of Treatment

Diagnosis

If the member is pregnant, what is the expected date of delivery?	Is treatment for an exacerbation of a previous injury or chronic condition? ☐ Yes ☐ No

Current Treatment/Comments

Physician's Signature *Date*

Please return both pages of this completed form and any pertinent medical records to:

By fax: **1-800-280-7346**

By mail: ATTN: UTILIZATION MANAGEMENT DEPARTMENT PROSPECTIVE REVIEW
MVP HEALTH CARE
PO BOX 2207
SCHENECTADY NY 12301-2207

For Internal MVP Use Only

MVP Medical Director Name	Transition of Care Benefits Approval? ☐ Approved ☐ Not Approved

Comments

MVP Medical Director's Signature *Date*