

GDCH APPLICATION FOR TRANSITION OR CONTINUATION OF CARE

Mail to:
UnitedHealthcare
4170 Ashford Dunwoody Rd., Suite 100
Attn: Transition of Care
Atlanta, GA. 30319
OR
Fax to: 1-800-257-9694
OR send email to: PEACH@UHC.COM

Georgia Department of Community Health Employee/Applicant:

Transition of Care is a service which enables UnitedHealthcare *new* enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Continuation of Care is a service which enables UnitedHealthcare *existing* enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OR CONTINUATION OF CARE BENEFITS?

- Read & *complete* SECTION 1 of the application when applying for *either* Transition or Continuation of Care.
- If you answer YES to at least one question, you may be eligible for Transition or Continuation of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition or Continuation of Care benefits. Should you require assistance locating a new physician in the UnitedHealthcare network, please visit us online at www.myuhc.com or call the customer care number shown on your medical ID card.

THE APPLICATION PROCESS

1. *Complete SECTION 2* if you answered YES to at least one of the questions in SECTION 1.
 - **Proceed to SECTION 2 only if you answered YES to at least 1 question in SECTION 1.**
 - Be sure to sign the authorization form to release your medical records.
2. Ask your physician to *complete SECTION 3* of the application.
 - **If you are receiving care from more than one physician, each one must individually complete SECTION 3.**
3. Mail or fax the completed application along with relevant medical records to the address or number noted on the top of this application **prior to 30 days following the effective date** of your UnitedHealthcare plan. If you submit this application after the 30th day of your coverage effective date, you will not be eligible for the Transition of Care service. **Continuation of Care eligibility is based upon qualifying events listed in SECTION 1 and not your coverage effective date.**

SECTION 1	TO BE COMPLETED BY APPLICANT	
Are you in your last 2 nd or 3 rd trimester of pregnancy or did you deliver less than 6 weeks ago?	YES	NO
Are you pregnant and has your doctor told you this is a moderate or high-risk pregnancy?	YES	NO
Are you scheduled for surgery with a provider within 30 days of plan start or UHG network term date?	YES	NO
Are you currently actively participating in a diabetes, coronary artery disease, heart failure or asthma disease management program with a registered nurse and receiving a co-pay waiver?	YES	NO
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	YES	NO
Are you undergoing treatment for symptomatic AIDS?	YES	NO
Are you undergoing treatment for severe or end-stage kidney disease?	YES	NO
Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	YES	NO
Are you currently undergoing an active course of treatment for any other serious medical condition? Describe	YES	NO

For consideration of mental health and substance abuse services contact the mental health and substance abuse review organization at the telephone number included in your enrollment information or on your medical ID card.

SECTION 2				TO BE COMPLETED BY APPLICANT	
Employee Name		Social Security Number			
Address		City	State/Zip Code		
Home Phone Number		Work Phone Number			
Employer Name			Plan Effective Date		
Patient Name			Patient's Date of Birth		
Patient's Relationship to Employee (i.e., spouse, dependent, self)					
Are you currently covered by:		Are you currently covered by other insurance?		YES	NO
Medicare	Medicaid	If yes, which company?			

