Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company

Cigna®

Attachment 1

Transition of Care Request Form

This form needs to be completed to request in-network coverage for continued services received from a non-participating provider. Please check the provider directory on **myCigna.com** to verify if your provider is in the Cigna network.

Use a separate form for each condition. Photocopies of this form are acceptable. Attach additional information if necessary.

EMPLOYER			POLICY #
EMPLOYEE NAME	DATE OF ENROLLMENT IN BENEFIT PLAN (mm/dd/yyyy)	EMPLOYEE SOCIAL SECURITY #	WORK PHONE
HOME ADDRESS Street City State Zip			HOME PHONE
PATIENT'S NAME	PATIENT'S SOCIAL SECURITY #	PATIENT'S DOB (mm/dd/yyyy)	RELATIONSHIP TO EMPLOYEE ☐ Spouse ☐ Dependent ☐ Self

1. Is the patient applying for Transition of Care benefits because their physician is leaving the network? ☐ Yes ☐ No
2. Is the patient pregnant and in the second or third trimester (>12 weeks) of pregnancy? ☐ Yes ☐ No
3. If yes, when is the due date? ________________ (mm/dd/yyyy) ☐ Yes ☐ No
4. Is the patient receiving care for end-stage renal disease and dialysis? ☐ Yes ☐ No
5. Is the patient in outpatient mental health treatment? ☐ Yes ☐ No
6. Does the patient have a terminal illness with anticipated life expectancy of six months or less? ☐ Yes ☐ No
7. Is the patient undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the patient's health? ☐ Yes ☐ No
8. Is the patient currently undergoing chemotherapy or radiation therapy for treatment of cancer? ☐ Yes ☐ No
9. Is the patient a candidate for a solid organ or bone marrow transplant? ☐ Yes ☐ No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient is requesting Transition of Care coverage. ____

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PHYSICIAN'S GROUP/PRACTICE NAME		
PHYSICIAN'S NAME		PHYSICIAN TELEPHONE #
PHYSICIAN'S SPECIALTY		
PHYSICIAN'S ADDRESS		
NAME OF HOSPITAL(S) AT WHICH PHYSICIAN PRACTICES		HOSPITAL TELEPHONE #
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		

11. Is this patient expected to be in the hospital when coverage with us begins, or during the next 90 days?
12. Please list any other continuing care needs that may qualify for Transition of Care benefits. If care needs described are not associated with the condition for which you are applying for Transition of Care benefits, then a separate Transition of Care form must be completed.

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I hereby authorize any insurance company, health care provider, or other entity having knowledge of the person identified on this form to give Cigna or its designated agent(s) any and all records pertaining to that person's medical, mental/nervous, and/or substance abuse history for purposes of review, investigation, or evaluation by our administrative staff. This authorization is valid for six months from the date that I sign it. I, or my authorized representative, is entitled to a copy of this signed authorization.	
SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE (mm/dd/yyyy)

INSTRUCTIONS FOR COMPLETING THE TRANSITION OF CARE REQUEST FORM

- A separate Transition of Care Request Form must be completed for each condition for which you or your dependents are seeking Transition of Care benefits. Additional forms are available from your employer or from Cigna. Please make certain that all questions are answered completely.
- The first few sections of the form apply to the Employee. When the form asks for the patient's name, print only the name of the person who is actually undergoing care and is requesting Transition of Care.
- If responding to question # 10, include information about your current or proposed treatment plan and length of time your treatment is expected to continue. If surgery has been planned, state the type and the proposed date of your surgery.
- For question #12, briefly state the health condition, when it began, the name of the physician(s) currently involved in treating the condition, and how often the physician is seen. Please be as specific as possible.
- When the form is completed, it should be signed by the patient for whom Transition of Care benefits are being requested. If the patient is a minor, a guardian's signature is required.

To help ensure a timely review of your transition case, please return the form as soon as possible. As noted below, you must apply for Transition of Care within the first 60 days after the effective date of coverage or the date your physician leaves the network.

Completed forms should be marked "Confidential" and sent to the Medical Management Office. Mail or fax the claim to:

Cigna Health Management
13045 Tesson Ferry Road, F0-22
St. Louis, MO 63128
Fax: 866-729-0432

Our Medical Management Department will review Transition of Care Requests within 15 days of receipt. Organ and tissue transplant requests may take longer.

If your request for transition of care benefits is not approved, such determination should not be interpreted as a denial of medical necessity or the availability of benefits under your plan. Please refer to the terms of your benefit plan for coverage information by non-network providers and the applicable benefit level.

Members will be notified in writing of the approval or non-approval of the request and appeal rights. For questions, please contact us at the telephone number listed on your ID card.

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