AFFINITY MEDICAL GROUP

Transition of Care Form

(To be used when a member changes from another Medical Group to Affinity Medical Group)

Our goal is to provide benefits for continuity of care for any new member of Affinity Medical Group who is receiving prenatal care or is in ***active*** *treatment for an acute or chronic condition with a* non participating provider. Visits through the current period of active treatment **or** up to 90 days, depending on the care needs and circumstances will be approved. If the member chooses to continue her prenatal care with an out of network provider, the visits may be approved if the member is receiving prenatal care during the second or third trimester of pregnancy and will continue through the provision of post-partum care directly related to the delivery.

If you or any covered family member are receiving care of this kind from a non participating provider, please complete this form. Any information provided will be kept confidential by Affinity Medical Group and will only be used in accordance with applicable privacy laws. Affinity may share this information with your primary care provider (PCP) and/or specialist and may be in contact with you to facilitate continuity or continuation of care.

Subscriber/Employer Info:

Subscriber Name: _____ Coverage Effective Date: _____

Group Number: _____ Employer Name: _____

Type of Coverage, i.e., (HMO, PPO) _____

Patient Info:

Patient Name: _____ Patient DOB: _____ Patient ID#: _____

Patient Address: _____

Home Telephone #: _____ _____ Work Telephone #: _____

Best time to contact: _____

Provider Info:

Primary Care Provider (PCP): _____

PCP Address: _____

PCP Telephone #: _____

1) Specialist Name: _____ Telephone #: _____

Specialist Address: _____

2) Specialist Name: _____ Telephone #: _____

Specialist Address: _____

Services Requested for Transitional Care: (check all that apply)

___ Ambulatory/Same Day Surgery ___ Durable Medical Equipment ___ GYN/infertility
___ Hospice Care ___ Inpatient Care (after surgery) ___ Mental Health
___ OB _____ (Date of Delivery) ___ Oncology ___ Out of Network Care
___ Outpatient Rehab (physical therapy, occupational therapy, speech therapy) ___ Pediatrics
___ Surgery _____ (Treatment Type of Surgery)
___ Transplant _____ (Type of transplant)
___ Other (please explain): _____
___ Chronic/Long-Term Illness: _____
Diagnosis: _____
Brief Description of active treatment being received: _____