Allegiance℠
a Cigna Company

What is Transition of Care?

Transition of care coverage allows you to continue to receive services for specified medical conditions for a defined period of time with health care professionals who do not participate in the FH or OH network until the safe transfer of care to a participating doctor or facility can be arranged. You must apply for Transition of Care at enrollment, or change in Disney medical plan, but no later than 30 days after the effective date of your coverage.

What is Continuity of Care?

Continuity of Care allows you to receive services at in-network coverage levels for specified medical conditions for a defined period of time when your health care professional leaves the FH or OH network and there are solid clinical reasons preventing immediate transfer of care to another health care professional. If your health care professional is leaving the FH or OH network, you must apply for Continuity of Care within 30 days of the health care professional's termination date.

How Transition of Care/Continuity of Care Works

~You must already be under treatment for the condition identified on the Transition of Care/ Continuity of Care request form.
~If Transition of Care/Continuity of Care is approved for medical conditions, you will receive the in-networklevel of coverage for treatment of thespecific condition by the health careprofessional for a defined time frame, asdetermined by Allegiance. If your planincludes out-of-network coverage and youchoose to continue care out of networkbeyond the time frame approved byAllegiance, you must follow your plan'sout-of-network provisions. This includesany pre-certification require ments.
~If approved, Transition of Care/Continuity of Care coverage applies only to the treatment of the medical condition specified and thehealth care professional identified on therequest form. All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage levels.
~The availability of Transition of Care/ Continuity of Care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-certification may still be required for a service to be covered.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

~Pregnancy in the second or third trimester at the time of the effective date of coverage or time of health care professional termination.
~Pregnancy is considered a 'high risk' such as early delivery (3 weeks) in previous pregnancy, patient has had/or has gestational diabetes, pregnancy induced hypertension, multiple inpatient admissions during this pregnancy, mother's age is > 35 years old.
~Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
~Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
~Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions, etc. For the purpose of this policy, "active treatment" is defined as a doctor visit or hospitalization with documented changes in a therapeutic regimen within 21 days prior to your plan effective date or your health care professional's termination date.
~Recent major surgeries still in the follow-up period (generally 6 to 8 weeks).
~Trauma.
~Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).

Examples of conditions that do not qualify for Transition of Care/ Continuity of Care include, but are not limited to:

~Routine exams, vaccinations and health assessments.
~Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma.
~Acute minor illnesses such as colds, sore throats and ear infections.
~Elective scheduled surgeries such as removal of lesions, bunionectomy, hernia repair and hysterectomy.

What time frame is allowed for transitioning to a new participating health care professional?

If Allegiance determines that transitioning to a participating health care professional is not recommended or safe for the conditions that qualify, services by the approved non-participating health care professional will be authorized for a specified period of time (usually 90 days) or until care has been completed or transitioned to a participating health care professional, whichever comes first.

If I am approved for Transition of Care/Continuity of Care for one illness, can I receive in-network coverage payments for a non-related condition?

In-network coverage levels provided as part of Transition of Care/Continuity of Care are for the specific illness/condition only and cannot be applied to another illness/condition. A Transition of Care/ Continuity of Care request form would need to be comp leted for each unrelated illness/condition no later than 30 days after coverage becomes effective or your health care professional leaves the FH or OH network.

Can I apply for Transition of Care/ Continuity of Care if I am not currently in treatment or seeing a health care professional?

You must already be in treatment for the condition that is noted on the Transition of Care/ Continuity of Care request form.

How do I apply for Transition of Care/Continuity of Care?

Transition of Care/Continuity of Care requests must be submitted usingthis form, at the time of enrollment, change in Disney medical plan, or when your health care professional leaves the FH or OH network, but no later than 30 days after the effective date of your coverage or your health care professional's termination. After receiving your request, Allegiance will review and evaluate the information provided and will send you a letter informing you whether your request was approved or denied. A denial will in clude information on appeals.

HealthCare Transition of Care/Continuity of Care Request Form

New HealthCare enrollee (Transition of Care applicant) Existing HealthCare member whose provider terminated (Continuity of Care applicant) Use a separate form for each condition. Photocopies are acceptable. Attach additional information if need.

Employer	Policy#	Employee date of Enrollment in Healthcare Plan (mm/dd/yyyy)
Employee Name	Employee SS# or Alternative ID	Work Phone
Home Address Street City State	Zip	Home Phone/Cell Phone
Patient's Name	Patients SS# or Alternative ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee Spouse Dependent Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date _____(mm/dd/yyyy) Yes No
2. If yes, is your pregnancy considered high risk? e.g., multiple births, gestational diabetes, etc. Yes No
3. Is the patient currently receiving treatment for an acute condition or trauma? Yes No
4. Is the patient scheduled for surgery or hospitalization after your effective date? Yes No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? Yes No
6. Is the patient receiving treatment as a result of a recent major surgery? Yes No
7. Is the patient receiving dialysis treatment? Yes No
8. Is the patient a candidate for organ transplant? Yes No
9. Is the patient receiving mental health/substance abuse treatment? Yes No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.
11. Is this patient expected to be in the hospital when coverage begins or during the next 90 days? Yes No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care coverage. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care coverage, you need to complete a separate Transition of Care/ Continuity of Care Form.

Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name		Health Care Professional Phone #
Health Care Professional Specialty		
Health Care Professional Address		
Hospital Where Health Care Professional Practices		Hospital Phone #
Hospital Address		
Reason/Diagnosis		
Dates of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt of all necessary information. Review for Organ Transplant requests may take longer than 10 days.

I hereby authorize the above provider to give CIGNA HealthCare or any affiliated CIGNA company any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/ Continuity of Care Benefits under CIGNA HealthCare. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Please return form to:
CIGNA–Allegiance Benefit Plan Management, Inc
Attention: Claims
PO Box 3018
Missoula MT 59806-3018
Toll Free Fax: 1-866-201-0522