Understanding Transition of Care and Continuity of Care

For members of New Jersey UnitedHealthcare and Oxford fully insured plans.

New members (Transition of Care)

New members may request benefits for treatment received from their current, out-of-network health care provider at the network benefit level for a short period of time from when they become a member so they may transition to a network provider. We will also honor an authorization approved by your previous carrier if the services are covered under your new plan. You will need to notify us of any previously authorized services so we can determine your eligibility for coverage at the network benefit level.

When your provider leaves the network (Continuity of Care)

Members in an ongoing course of treatment may request Continuity of Care (COC) from their current health care provider if the provider leaves their health plan network and is now considered an out-of-network provider. This coverage is available from the date the provider is no longer participating in the network. The provider will accept our network rates and follow our policies and procedures.

How to make a request

Members may use the form beginning on page 4 or call the number on your health plan ID card for assistance with requesting TOC or COC. New members who don't have a prior authorization from their previous carrier may also use this form to request Transition of Care.

How Transition of Care and Continuity of Care works

To be eligible, you must already be under active and current treatment by the identified out-of-network provider for the condition identified on the TOC and COC form below.

- Your request will be evaluated based on applicable federal law, state law, and accreditation standards
- Coverage at the network level is available if the provider agrees to accept our network rates, provide medical records, and follow our policies and a treatment plan approved by us
- If your request is approved for the medical condition(s) listed in your form(s), you will receive the network level of coverage for treatment of the specific condition(s) by the provider according to the time frames listed below or until care has been completed, whichever comes first
- After this time, network coverage ends. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame we approve, you must follow your plan's out-of-network requirements, including any prior authorization requirements.
- All other services or supplies must be provided by a network provider for you to receive network coverage levels

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- If your plan does not include out-of-network coverage, you can call the number on your health plan ID card for assistance
- The availability of TOC and COC coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

Examples of medical conditions that may qualify for Transition of Care and Continuity of Care:

New Members (Transition of Care)

- **You do not have an existing authorization from your previous carrier.** You may be covered for care that is medically necessary for up to 90 days.
- **You have an existing authorization from your previous carrier for services covered under your new plan.** You may be covered for care up to the time remaining in the previous carrier's authorization.

Existing Members (Continuity of Care)

- **You're pregnant.** You may be covered for care that is medically necessary for up to 90 days and may be longer when you are undergoing a course of treatment for the pregnancy. Coverage for pregnancy after a normal, vaginal delivery includes up to 6 weeks of postpartum care or, if you have a Caesarean Section, you may be covered for up to 6 months.
  - Coverage for newborn children begins at the moment of birth and continues for 60 days
  - You must notify your health plan representative within 60 days from the baby's date of birth to add the baby to your plan
- **You're getting Oncological (cancer) care.** You may be covered for care that is medically necessary for up to 1 year.
- **You had surgery.** You may be covered for care that is medically necessary for up to 6 months.
- **You're getting other medically necessary care covered by your plan.** You may be covered for up to 4 months.

Examples of conditions that do not qualify for Transition of Care and Continuity of Care:

- Routine exams, vaccinations and health assessments
- Minor illnesses such as colds, sore throats and ear infections

Frequently asked questions

How can I find a new network health care provider?

You can use the provider search feature of your member website, **myuhc.com®**, or call the phone number on your health plan ID card for assistance.

If my request is approved for one medical condition, can I receive network coverage for a non-related condition?

No. Network coverage levels provided as part of TOC and COC are for the specific medical conditions only and cannot be applied to another condition. If you are seeking network level of benefits for more than one medical condition, you will need to complete a separate request for each specific condition.

Behavioral health support

For behavioral health services, please call your behavioral health carrier at the phone number for members on your health plan ID card.

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To complete this form:

- Please make sure all fields are completed, including provider's signature
- When the form is complete, it must be signed by the member for whom the Transition of Care or Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- It is recommended that you request
  - TOC once you are eligible for benefits
  - COC when your provider is no longer in-network
- A separate TOC and COC Form must be completed for each condition for which you and/or your dependents are seeking TOC and COC

Please fax or mail the completed form, along with relevant medical records and information, within 30 days following the effective date of your plan, to:

UnitedHealthcare/Oxford
Fax: 1-855-686-3561 or Mail: UnitedHealthcare/Oxford
600 Airborne Parkway
Cheektowaga, NY 14225
Attn: Transition of Care/Continuity of Care

- After receiving your request, we will review and evaluate the information provided. Incomplete forms will be returned to the requestor. If the form is complete, we will send you a letter to let you know if your request was approved or denied. Completion of this request does not guarantee that a TOC or COC request will be granted.

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Transition of Care and Continuity of Care Form

This form is for all fully insured members covered under a New Jersey insurance policy, regardless of state of residence.

Member information

New UnitedHealthcare/Oxford member (Transition of Care) Existing UnitedHealthcare/Oxford member whose care provider terminated (Continuity of Care)		Provider Termination Date
Name (Person being treated)	Member ID Number	Date of Birth (mm/dd/yyyy)
Address	City	State/ZIP Code
Home/Cell Phone Number	Work Phone Number	
Employer Name	Date of Enrollment in the Plan (mm/dd/yyyy)	
Member's Relationship to Employee Self Spouse Dependent Other	Is the member currently covered by other health insurance carrier? Yes No If yes, carrier name:	

Authorization to release records:

I authorize all physicians and other health care professionals or facilities to provide UnitedHealthcare/Oxford information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for and if approved, coverage of Transition of Care/Continuity of Care benefits under the plan.

Member's Signature/Parent or Guardian's Signature if Member is a Minor	Date (mm/dd/yyyy)

Care Provider Section: Your health care professional should complete the following information

Name	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number
Address	City	State/ZIP Code
Hospital		Hospital Phone Number
Date of Last Visit (mm/dd/yyyy)	Next Scheduled Appointment (mm/dd/yyyy)	Frequency of Visits
Diagnosis	Expected Length of Treatment	If Maternity: Expected Date of Delivery (mm/dd/yyyy)

Please select 1 of the descriptions if it applies:

Life-Threatening Condition Acute Condition Transplant Inpatient/Confined
Upcoming Surgery Disabled/Disability Terminal Illness Ongoing Treatment

Is the treatment for an exacerbation of a previous injury or chronic condition? Yes No

Current and Associated Treatment(s)/Comments (include all relevant CPT codes)

If these care needs are not associated with the condition for which you are requesting for Transition of Care or Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care Form for each condition.

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We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree (1) to provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, (2) to follow our policies and procedures, (3) upon request, to share information regarding the member's treatment with us, (4) if applicable, to make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, to request any required prior approval before the services are rendered. Please note the following:

- For providers leaving our network: The terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any copayment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover, nor accept any payment from the member, us, or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge.
- For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level for members who do not have an authorization from the previous carrier for 90 days and for members with an authorization from the previous carrier for the time frame in the authorization. Payment will be on a fee-for-service basis at 100% of the Medicare applicable rate using the participating regional fee schedule along with our reimbursement rules and will be based on the postal ZIP code of your primary office. If coverage at the network benefit level is available, you agree to accept payment from us along with any copayment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover, nor accept any payment from the member, us, or any payer or anyone acting on their behalf, in excess of this amount, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional

Date (mm/dd/yyyy)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime, and may also be subject to a civil penalty for each violation.

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