Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 9910, Daytona Beach, FL 32120
www.fhcp.com

Transition of Care Form

Welcome to Florida Health Care Plans! It is the goal of the Transition of Care Team to assist you with transitioning into our network of providers, pharmacies & covered medications. Please complete this form to help us make the transition as seamless as possible.

Instructions – Please complete the TRANSITION OF CARE FORM with the attached authorization forms; provide as much information as possible. The authorization forms allow the RELEASE & REQUEST of Protected Health Information in order to better assist you. You will be contacted if additional information is needed.

Please return all forms to the Transition of Care Nurse Navigator by fax at 386-238-3271 or by mail to FHCP Case Management Coordination of Care Department, Attn: TOC Nurse Navigator, PO Box 9910, Daytona Beach, FL 32120.

Questions can be directed to Case Management (CM) Coordination of Care Department at 855-205-7293 or to the Transition of Care line at 386-615-5017. Hours of operation are Monday through Friday, 8:00 am to 5:00 pm. The hearing impaired may call TRS Relay 711. We are happy to assist you in transitioning into your health coverage with Florida Health Care Plans.

Member Name: _____ **Member #:** _____
DOB: _____ **Gender:** _____
Address: _____

_____

Preferred Phone #: _____
Alternative Phone #: _____
Email Address: _____
Emergency Contact (Name, Relationship & Phone #):

Name	Relationship	Phone #

If you wish for your Protected Health Information (PHI) to be released to others, please complete, sign and return the attached Authorization to Release PHI form.

Current Medical Concerns - _____

_____

_____

_____

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PCP (Name, Phone #, City & State) - _____

_____

Last Visit - _____

SPECIALISTS (Name, Specialty, Phone #, City & State, Hospital/Group Affiliation)-

Name	Specialty	Phone	City/State	Hospital/Group Affiliation

UPCOMING APPOINTMENTS or PROCEDURES please use the NOTES section on page 4 if additional space is needed -

Date	Provider	Procedure	Visit Type

RECENT VISITS TO EMERGENCY ROOM or URGENT CARE? (Date, Name/Location of ER or UC, Reason for Visit) -

Date	Name/Location	Reason

In order for FHCP to request your medical records from your out-of-network providers, please complete, sign & return the attached AUTHORIZATION TO REQUEST PHI Form.

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CURRENT MEDICATIONS (Drug Name, Dose, Frequency, Prescribing Provider Name) – If you are submitting a Medication Transition Form, skip this section. Please note if free samples or enrolled with patient assistance programs.

Drug name	Dose	Frequency	Prescribing Doctor

Current Pharmacies Used (Name, Location & Phone #, Samples, or Patient Assistance Program)

Pharmacy/Patient Assistance program/Samples from	Location	Phone

DURABLE MEDICAL EQUIPMENT & OTHER MEDICAL SUPPLIES (Oxygen, CPAP, Insulin Pump, Ostomy supplies etc.). Please include name of supplier & prescribing provider. –

DME/Supplies	Company/Supplier	Contact number	Prescribing Provider

Are you in danger of running out of any medication, DME or medical supply in the near future or soon after your effective date with FHCP? □ **YES** □ **NO**

If YES, please list the name of the medication, medical equipment, or supply with the approximate date you will be without.

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NOTES:

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Disclaimer – Standard Prior Authorization procedures & guidelines apply. Transition of Care is a service for new members transitioning into the FHCP network. Submitting this form does not guarantee continued care with out-of-network providers, pharmacies, medical suppliers, or coverage of non-formulary medications. You may be financially responsible for charges if you receive services outside of the FHCP network without an approved authorization. It is your responsibility to notify your providers of your insurance change.

TOC RN Navigator Use Only:

PLAN TYPE (Circle One) – MCARE / QHP / SELF / COMM
GROUP - _____
PLAN CODE - _____
HMO, POS, TROP (Circle One)
RIDERS – _____
EFF - _____

TO DO:
ROI forms received? □ **YES** □ **NO**
ROI forms in EHR? □ **YES** □ **NO**

□ **Tasked Med Rec Team in EHR to obtain records.**
□ **Reviewed TOC Form**
□ **Initial Call w/Member**
□ **Discuss PAR Pharms – Closest =** _____
□ **Mail Order Pharmacy Information Given**
□ **Discuss closest EHCC – Closest =** _____
□ **Identify Rx needing PAs, formulary exceptions.**
□ **Contact Pharm Svcs for comparable form meds if non-form meds exist.**
□ **Notify Referrals of potential incoming PA reqs.**
□ **Task COC CM for complex issues & CRC needs.**
□ **Task UR CM for ongoing In-Pt, HH or SNF.**

BENEFITS:
DEDUCTIBLE = _____ **MOOP =** _____
PCP COPAY = _____ **SPECIALIST COPAY =** _____
EHCC COPAY = _____ **U/C COPAY =** _____
ER FACILITY COPAY = _____ **ER PROVIDER COPAY =** _____
AMBULANCE COPAY = _____

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION (PHI)

FLORIDA HEALTH CARE PLANS ● P.O. BOX 9910 ● DAYTONA BEACH, FL 32120
PLEASE FAX MEDICAL RECORDS TO: 386-481-5009 OR 888-427-4544

FHCP Medical Record #: _____ Birth Date: _____

Patient Name and Maiden Name: _____ Social Security # _____

Address: _____

Home Phone #: _____ Work #: _____

I hereby authorize FHCP to obtain my previous medical records from:

Facility/Provider: _____ **Phone#** _____ **Fax#** _____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

Purpose for release: ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Patient Request ☐ Other

Please release the following information contained in my medical records regarding my care/treatment to FHCP:

☐ All Records ☐ Immunizations	☐ Office Visits ☐ Radiology Reports	☐ Operative Reports ☐ Labs/Date drawn _____ ☐ Other _____

Date(s) of Service: _____

I understand that all of my medical records may be faxed to FHCP unless specified here - ☐ Mail (above P.O.Box)

If a Sensitive Information box is checked below, the patient must initial to authorize the release of this information.

☐ HIV/AIDS information _____	☐ Drug and Alcohol _____	☐ Psychiatric _____	☐ Other _____

I understand that this authorization extends to all or any part of my records, which may include psychiatric, alcohol/drug, and/or AIDS (Acquired Immunodeficiency Syndrome) information, and may include the result of an HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, or facsimile machine (fax) or any other FHCP approved means. **I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to an FHCP Medical Records Department. I understand that the revocation will not apply to information that has already been released as requested by this authorization. I understand that any disclosure of information carries with it the potential for redisclosure where confidentiality laws or regulations may not apply. It also prohibits FHCP from making any further disclosure without the specific written authorization of the person to whom it pertains. I understand that FHCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether or not I sign this authorization.**

Release of PHI Request Expiration Date: (Must check a box or enter an "Expiration Date")
☐ Upon Death Or Expiration Date / / Or ☐ one year from the date of signature

_____ _____
Signature of Patient or Legal Representative/Authorized Health Surrogate* Date

_____ _____
Witness Date

*****Legal Representative/Authorized Health Care Surrogate is defined as a court appointed guardian or personal representative, a person with a Health Care Power of Attorney specific to medical records access, a person designated as a Health Care Surrogate, or next of kin. Supporting documentation required.