BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Florida Transition of Care/Continuation of Care

Purpose of Transition of Care and Continuation of Care

If circumstances change and a member's provider is not in-network or no longer in-network, BlueCross strives to make the transition seamless. A member with these circumstances can make a special request to have benefits with their original provider paid at the in-network level for a limited amount of time.

Transition of care is also referred to as treatment in progress. It is available for new members who are being treated for an acute injury or illness by a provider who is not in our network when his or her coverage begins with us. It is a benefit that, if approved, allows new subscribers and covered dependents to receive medical or behavioral health care by non-participating providers. Treatment is at the in-network benefit level for an acute injury or illness. Transition of care is short term and doesn't replace the regular provisions of the program. This is when the patient should be working with his or her primary care physician or participating provider to access continued, ongoing care.

Continuation of care allows benefits for members to continue care with a network provider that is leaving the network. Continuation of care requires approval from medical management. If approved, members are allowed network level benefits for a limited amount of time.

Examples of medical or behavioral health conditions that may meet Transition of Care or Continuation of Care guidelines:

- Women in the second or third trimester of pregnancy
- Acute fracture victims or heart attack victims under acute care
- Newly-diagnosed cancer patients currently undergoing approved surgery, chemotherapy or radiation treatment protocols
- Diagnosed terminally ill patients for whom life expectancy is less than 60 days
- Members hospitalized at the time of eligibility
- Physical therapy status — post total joint replacement
- Outpatient, follow-up treatment with a specific provider if a member is involuntarily committed or under a court order

Examples of medical or behavioral health conditions that May Not meet Transition of Care or Continuation of Care guidelines:

- Routine examinations, vaccinations and health assessments
- Stable but chronic conditions (e.g., diabetes, allergies, arthritis, asthma, hypertension, depression, anxiety, bipolar disorder)
- Minor illnesses (e.g., colds, sore throats, ear infections, bronchitis, strains, sprains)
- Elective scheduled surgery (e.g., removal of lesions, hernia repairs, hysterectomies)
- Long-term management of cancer, dialysis, transplants, etc.

Transition of Care and Continuation of Care Benefit Enrollment Process

Submit all requests for transition of care in writing via fax to 803-264-9175, or by email: transitionofcare@bcbssc.com.
Mail to:

BlueCross BlueShield of South Carolina
Att: Transition of Care AX-F21
P.O. Box 100228
Columbia SC 29202

Transition Review Process

Upon receipt of the request form, our Managed Care Services department will review and evaluate the information. Based upon this initial information, we will inform the member in writing of the decision in one of three ways:

1. Request for transition of care approved for a specific period of time or a specific number of visits
2. Request for transition of care denied
3. Request for additional information needed before we can make a final decision

This review process normally takes approximately 10 business days. We will do our best to expedite this.

We will deny benefits for care received from non-participating providers after the transition period has expired or we will pay it at the out-of-network benefit level.

BlueCross BlueShield Transition of Care
Continuation of Care Form
(Please use a separate form for each condition)

Employee's Name ID #

Address City/State/ZIP

Effective Date

Phone:(Home)_____(Work): _____

Patient's Name DOB ID #

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Dependent

Health Condition: _____

Physician/Provider(s) Involved

Name: _____Phone :_____Specialty: _____

Name: _____Phone:_____Specialty: _____

Name: _____Phone:_____Specialty: _____

Date of First Treatment:_____Date of Last Visit: _____

Current Treatment or Proposed Surgery: _____

Expected Length of Treatment or Date of Surgery: _____

Primary Care Physician

Provider's Name Member Health Plan ID #

Address

City/State/ZIP

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____

Non-Participating Specialist's Name

_____

Address and Phone Number

To release to BlueCross BlueShield of Florida all information relating to past, present and future health care examinations, conditions and treatments for:

_____

Brief Description of Medical Condition

_____

I hereby authorize BlueCross BlueShield of Florida's Managed Care Services to get any information and medical records necessary from the above physician(s) necessary to make an informed decision concerning my request for treatment in progress benefits under my medical plan. This authorization will expire six months from the date signed below. I understand I am entitled to a copy of this authorization form.

I understand that I may be balance billed by the provider for the difference between our allowance and the providers' charges. I am also responsible for the member liability for deductibles, coinsurance and copayments. I understand that if the Plan pays all benefits to me that I will be responsible for paying any amounts owed to the provider.

Patient's Name: _____ Health Plan ID #: _____

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature*: _____ Date: _____

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊 息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

غلبن م ذ ود ةيا ذ إ ن اك كيدل و أ د دل ص خش هعاست ةلئسأ صوصخب ةطخ ةحصلا هذه، كيدلف ق حلا ي ف ل وصحلا
ةفلكتلا دحتلل عم مجرتم ل صتا ب 1-844-396-0189 (Arabic) ى لع ةدعاسملا تامولعملاو

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険　　についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳　とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

رگا اهش ایـ یـدرف هکـ هبـ وا کمک یم دینک یتلااؤس رد یهرابـ یهمانـربـ یتشادهب
باشید، قح نیا ار دیراد هکـ کمک و تاعلاطا هبـ نابز دوخ ار هبـ روط ناگیار نیا هتشاد

1-844-398-6233 ردیفات کنید. برای بحصت رکدن با مترمج، لطفاًبا مشاریه
هتاس حاصل

(Persian-Farsi) دییامنـ.