Health Plan of Nevada
Sierra Health and Life

Understanding Transition of Care and Continuity of Care.

Transition of Care gives certain new HPN/SHL members with specific medical conditions the option to request extended coverage from their current out-of-network healthcare professional at network rates for a limited time. You must apply for Transition of Care no later than 30 days after the date your HPN/SHL coverage begins.

Continuity of Care gives existing HPN/SHL members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period of time.

Examples of covered medical conditions can be found on pages 1-2 of this document.

If your health care professional is leaving the HPN/SHL network, or if you are a new HPN/SHL member, you must apply for Transition of Care or Continuity of Care within 30 days of the health care professional's termination date or within 30 days from your effective date, using the form beginning on page 3.

How Transition of Care and Continuity of Care works:

You must already be under active and current treatment by the identified non-contracted health care professional for the condition identified on the Transition of Care and Continuity of Care form below.

Your request will be evaluated with consideration for applicable Federal law, State law and accreditation standards.

- 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 health care professional for a defined time frame, as determined by HPN/SHL. All other services or supplies must be provided by a network health care professional for you to receive network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the time frame approved by HPN/SHL, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements.
- The availability of Transition of Care and Continuity of Care 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 termination and formal prior authorization may still be required in order for a service to be covered.

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

- Pregnant and undergoing a course of treatment for the pregnancy.
  - Coverage for newborn children begins at the moment of birth and continues for 31 days. You must select an in-network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries in the acute phase and follow-up period (generally six to eight weeks after surgery).
- Serious acute conditions in active treatment such as heart attacks or strokes.
- Other serious chronic conditions that require active treatment.

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

- Routine exams with your primary care provider for vaccinations and health assessments
- Chronic conditions such as diabetes, arthritis, allergies, asthma, kidney disease and hypertension that are stable.
- Minor illnesses such as colds, sore throats and ear infections.
- Elective scheduled surgeries.

Frequently asked questions:

What can I expect after the completed form is submitted?
You will receive a written decision either approving or denying your request. We encourage you to find a doctor, healthcare professional or facility (like a hospital) in your health plan's network.

If I am approved for Transition of Care and Continuity of Care for one medical condition, can I receive network coverage for a non-related condition?
No. Network coverage levels provided as part of Transition of Care and Continuity of Care 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 submit a separate request for each condition.

Definitions:

Transition of Care: Gives certain new HPN/SHL members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time. This extended coverage only applies to specific medical conditions, until the safe transfer to a network health care professional can be arranged.

Continuity of Care: Gives HPN/SHL members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Out-of-network: Services provided by a non-participating provider.

Pre-authorization: An assessment for coverage under your health plan before you can get access to medicine or services.

Active course of treatment: An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally an active course of treatment is defined as within the last 30 days, but is evaluated on a case-by-case basis.

Transition of Care and Continuity of Care Form

This form is for all fully insured HPN/SHL members. **For behavioral health services, please contact your behavioral health carrier.**

To complete this form:

- Please make sure all fields are completed. When the form is complete, it must be signed by the member for whom the Transition of Care and Continuity of Care is being requested. If the patient is a minor, a guardian s signature is required.
- You must complete and submit the form for Transition of Care and Continuity of Care within 30 days of the effective date of coverage or within 30 days of the care provider's termination date.
- A separate Transition of Care and Continuity of Care form must be completed for each condition you and/or your dependents are seeking Transition of Care and Continuity of Care.
- Please mail or fax the completed form, along with relevant medical records and information, within 30 days following the effective date of your HPN/SHL plan to:

  Health Plan of Nevada/Sierra Health and Life
  P.O. Box 14856
  Las Vegas, NV 89114-4856
  Attn: Transition of Care/Continuity of Care
  ProviderAdvocateTE@uhc.com

- After receiving your request, HPN/SHL 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 form does not guarantee that a Transition of Care and Continuity of Care request will be granted.

Member Information		
☐ New Health Plan of Nevada/Sierra Health and Life member (Transition of Care applicant) ☐ Existing HPN/SHL member whose care provider terminated (Continuity of Care applicant)		Provider Termination Date
Name (Person being treated)	HPN/SHL 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 HPN/SHL 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 HPN/SHL 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 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 (Treating physician or other health care professional)	National Provider Identifier (NPI) or Tax ID Number (TIN)	Phone Number Fax Number
Address	City	State/ZIP Code
Facility Name, NPI/TIN, Address, City, State		Facility 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

Newborn members: Coverage for newborn children begins at the moment of birth and continues for 31 days. You must select a network pediatrician and notify your health plan representative within 30 days from the baby's date of birth to add the baby to your plan.

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

Current Condition and Associated Treatment Plan (include brief statement and all relevant CPT codes*)
If these care needs are not associated with the condition you are applying for Transition of Care and Continuity of Care coverage, please complete a separate Transition of Care and Continuity of Care form for each condition.
*attach additional clinical, as needed.

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 to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable timeframe, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, 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, 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 in excess of this amount from the member, us, or any payer or anyone acting on their behalf, 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. Payment will be consistent with the member's benefit plan. 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 in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional	Date (mm/dd/yyyy)

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card or plan documents.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your health plan ID card or plan documents.

English: You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card or plan documents.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card or plan documents.

Español (Spanish): Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan o los documentos de su plan.

Tagalog (Tagalog): May karapatan kang makakuha ng tulong at impormasyon sa sinasalita mong wika nang libre. Upang humiling ng interpreter, tawagan ang toll-free na numero ng telepono para sa miyembro na nakalista sa iyong ID card sa planong pangkalusugan o sa mga dokumento ng plano.

繁體中文 (Chinese):
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，請撥打您健保計劃會員卡或計劃文件上的免付費會員電話號碼。

한국어(Korean): 귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드 혹은 플랜 문서에 기재된 무료 회원 전화번호로 전화하십시오.

Tiếng Việt (Vietnamese): Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID hoặc trên các tài liệu chương trình bảo hiểm y tế của quý vị.

አማርኛ (Amharic): በምትፈልጉት ቋንቋ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በጤና ካርድዎ ወይም የጤና ሰነዶች የተዘረዘረውን የማያስከፍል ቴሌፎን ይደውሉ። ጥያቄዎች ካሉዎት፣ አባክዎ ያስታውቁኝ። አመሰግናለሁ! አናሂ

ภาษาไทย **(Thai):**

คุณมีสิทธิ์ขอความช่วยเหลือหรือขอข้อมูลในภาษาของคุณโดยไม่เสียค่าใช้จ่ายใด ๆ เมื่อต้องการล่าม กรุณาโทรฟรีมาที่หมายเลขโทรศัพท์สำหรับสมาชิกที่อยู่บนบัตรแผนสุขภาพหรือเอกสารแผนสุขภาพของคุณ

日本語 (Japanese):
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。通訳をご希望の場合は、医療プランのID
カードまたはプランの資料に記載されているメンバー用のフリーダイヤルまでお電話ください
。

العربية (**Arabic**):
لديك الحق في الحصول على المساعدة والمعلومات بلغتك وبدون تكلفة. لطلب مترجم، اتصل بالرقم المجاني المدرج على بطاقة عضويتك في البرنامج الصحي أو وثائق البرنامج.

Русский (Russian): Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты или документах о вашем плане.

Français (French): Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé ou dans la documentation relative à votre régime.

فارسی (**Persian**):
.کنید دریافت رایگان صورت به خودتان زبان به را اطلاعات و راهنمایی تا هستید برخوردار حق این از شما
مربوط اسناد یا سلامت طرح شناسایی کارت در موجود رایگان تلفن شماره با ،شفاهی مترجم درخواست برای
بگیرید تماس طرحتان به.

Gagana fa'a Sāmoa (Samoan): E iai lau aia tatau e maua ai faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tasi e faaliliu, telefoni mai le numera o le telefoni e le totogia o lisi atu i lau pepa ID o le peleni tausoifua maloloina poo pepa mo le peleni.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte oder in den Versicherungspapieren.

Ilokano (Ilocano): Addaan ka ti karbengan a maala iti daytoy nga tulong ken impormasion para ti lenguahem nga awan ti bayadna. Tapno agkiddaw iti maysa nga tagapataros, awagan iti toll-free nga numero ti telepono para kadagiti kameng nga nakalista ayan iti ID card mo para ti plano iti salun-at mo wenno ayan dagiti dokumento ti planom.