Health Care Transition Form

Please complete this form if you or any of your dependents are pregnant, receiving ongoing specialty care or taking medications not covered by Quartz. If transition of care is approved, this is not a guarantee of benefits. Your deductibles, coinsurance and copayment will still apply and you may be responsible for amounts in excess of usual, customary and reasonable charges. ***If there is a difference between what the provider bills and what Quartz pays, your provider may bill you for the difference. This is known as balance billing and these charges do not apply to your plan's maximum out-of-pocket costs.***

☐ **Medical** ☐ **Pharmacy** ☐ **Both** ☐ **Behavioral Health**

Effective Date: _____ Employer Name: _____

Name: _____ Date of Birth: _____

Contact phone number and best time between 8 a.m. and 5 p.m. to call you: _____

Dependent Name: _____ Date of Birth: _____

Relationship to Employee: ☐ Spouse ☐ Dependent ☐ Self

If pregnant, please indicate due date: _____

Is this pregnancy considered high risk? (e.g., multiple births, gestational diabetes) ☐ YES ☐ NO

Description of medical condition and treatment. Please include any medications: _____

_____

_____

_____

Pharmacy only – please list any medications you have questions on
(e.g., is there a prior authorization requirement, specialty injectables): _____

_____

Durable Medical Equipment: _____

_____

Current physician(s) including location(s) and specialty: _____

_____

Any additional questions or areas of concern: _____

_____

Please complete the information above and return the form using one of the following methods –
Fax to: (608) 821-4207 Attn.: Medical Management Dept.
Mail to: Medical Management Dept., 2650 Novation Parkway, Madison, WI 53713