

# Transition of Care/ Continuity of Care **Information**

## Transition of Care

**Gives new plan participants** the option to request extended coverage from their current health care professional who will be out of network with the new plan. This is for limited time due to a specific medical condition, and may continue until the safe transfer to a network health care professional can be arranged. The provider must agree to accept network rates. Examples of qualifying medical conditions can be found below. You must apply for transition of care no later than 30 days after the date your coverage begins using the application.

## Continuity of Care

**Gives existing plan participants** the option to request to extended care from their current health care professional if he or she is, or is soon to be out-of-network. Plan participants 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 below. You must apply for continuity of care using the enclosed application.

## How Transition of Care/Continuity of Care Works

You are eligible for a Transition of Care/Continuity of Care only when you have a significant medical condition that requires you to continue care with a specific provider as determined in each individual situation.

If your request is approved for the medical condition(s) listed in your application(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 us. All other services or supplies must be provided by a network health care professional for you to receive in-network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving out-of-network care beyond the timeframe approved by us, you must follow your plan's out-of-network requirements.

Depending on the actual request, a medical necessity determination and a notification or prior authorization may still be required in order for a service to be covered.

## Examples of medical conditions that may qualify you for Transition of Care/Continuity of Care includes, but is not limited to:

- ✓ Pregnancy in the second or third trimester through six weeks post-delivery.
- ✓ Transition of Care for the mother does not apply to the newborn. If the care provider or facility is out-of-network for the newborn, please submit a network gap request for services for the newborn by calling the number on your member ID card.
- ✓ Ongoing treatment for a life threatening condition.
- ✓ Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- ✓ Ongoing treatment after a completed complex surgery or are in the middle of a staged surgery.
- ✓ Treatment for end-stage kidney disease and are on dialysis.
- ✓ Ongoing care after a recent organ transplant, or you are on the waiting list for a transplant with a specific physician.
- ✓ Ongoing treatment for acute significant psychiatric problems or other significant behavioral health services.
- ✓ Ongoing treatment for a rare and complex medical condition requiring continuity with a specific specialist.

## Examples of conditions that do not qualify includes:

- ✗ Routine exams and pediatric care; care of chronic conditions like as diabetes, arthritis, allergies, asthma, kidney disease and hypertension; elective surgeries and procedures.

### What do I do next?

Please fill out the enclosed form and do one of the following:

Please fill out the enclosed form and fax to  
**516.723.7392**

Or mail to:

**Quartz Align TOC, c/o Brighton Health Plan Solutions, LLC**  
**P.O. Box 8030,**  
**Garden City, NY 11530**



**Transition of Care** is a service which enables new plan participants to receive time-limited care for specified medical conditions from a non-contracted provider at the benefit level associated with contracted providers.

**Continuation of Care** is a service which enables Quartz Align existing plan participants to receive time-limited care for specified medical conditions from a non-contracted provider at the benefit level associated with contracted providers.

**Transition or continuity of care benefits application form**

**Complete SECTION 1 to determine if you are eligible for transition or continuity of care benefits**

- If you answer YES to at least one question, you may be eligible for Transition or Continuity of Care benefits.
- If you answer NO to every question, you are NOT eligible for Transition or Continuity of Care benefits.
- To locate a new provider in your Benefit Plan network, please visit us online at [quartzalign.com/members](http://quartzalign.com/members), login to your account and click on "Find a Provider".

**Complete SECTION 2 if you answered YES to at least one of the questions in SECTION 1.**

- Proceed to SECTION 2 **only if** you answered YES to at least 1 question in SECTION 1.
- Be sure to sign the authorization form to release your medical records.

**SECTION 3 needs to be completed by your physician OR healthcare provider treating your condition**

- If you are receiving care from more than one provider, you must complete this form for each provider.

Finally, mail or fax the completed application along with relevant medical records to the address or number noted at the bottom of the application.

- You must submit this form no longer than 30 days after your plan coverage through Quartz Align begins. If you submit this application after the 30th day of your new coverage effective date, you will not be eligible for the Transition of Care.
- Eligibility also depends upon qualifying events listed in SECTION 1

**Section 1: to be completed by applicant**

Select the type of care you are seeking coverage for:  Transition of Care (new member)  Continuation of Care (existing member)

Are you in your 2nd or 3rd trimester of pregnancy?	<input type="radio"/> Yes <input type="radio"/> No
Are you undergoing treatment for a life threatening condition?	<input type="radio"/> Yes <input type="radio"/> No
Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	<input type="radio"/> Yes <input type="radio"/> No
Are you undergoing treatment after a completed complex or staged surgery?	<input type="radio"/> Yes <input type="radio"/> No
Are you undergoing treatment for end-stage kidney disease and are on dialysis?	<input type="radio"/> Yes <input type="radio"/> No
Did you recently receive a transplant, or are you on the waiting list for a transplant with a specific provider?	<input type="radio"/> Yes <input type="radio"/> No
Are you undergoing treatment for significant acute psychiatric or behavioral health services?	<input type="radio"/> Yes <input type="radio"/> No
Are you undergoing treatment for a rare and complex medical condition requiring continuity with a specialist?	<input type="radio"/> Yes <input type="radio"/> No



**Section 2: to be completed by applicant**

Employee Name		ID Number	
Address		City	State/Zip Code
Home Phone Number		Work Phone Number	
Employer Name		New Plan Effective Date	
Patient Name		Patient's Date of Birth	
Patient's Relationship to Employee (i.e., spouse, dependent, self)			
Are you currently covered by other insurance: <input type="radio"/> Medicare <input type="radio"/> Medicaid <input type="radio"/> Other _____		TOC Provider Information: <input type="radio"/> Physician <input type="radio"/> Facility <input type="radio"/> Other Name: _____ Specialty (e.g. Heme-onc; Ob/Gyn, Hospital, etc.) _____	
<b>Authorization to release records:</b> I authorize all health care professionals or institutions to provide information concerning medical care, advice, treatment, or supplies for the patient named above.			
Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor		Date	(OVER)



**Section 3 to be completed by the Healthcare Provider (One form needs to be completed by each provider or facility that is agreeing to the condition of Transition or Continuation of Care)**

Please fill out and check the entire form for completeness and submit **all 3 sections** with any relevant medical notes to Quartz Align at the address listed below.

Section 3: to be completed by healthcare provider or facility currently treating condition			
Physician / Provider Name		Provider TIN Number	Provider Contact Phone Number
Address		City	State/Zip Code
Date of Last Visit		Next Scheduled Appointment	Frequency of Visits
Diagnosis Code	CPT Code	Expected Length of Treatment, or if maternity, expected date of delivery: _____	
E-mail address:		Is treatment for an exacerbation of a previous injury or chronic condition? <input type="radio"/> Yes <input type="radio"/> No	
<p>Treatment Plan &amp; Explanation why transition/continuation of care with the current provider/facility is medically necessary. Please list services/CPT you are planning to provide.</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>The above-named patient is a plan participant of Quartz Align. We understand you are not, or soon will not be a participating provider in the network. This plan participant has asked that for this episode of care, for a defined period of time, we treat claims from you for as in-network under the plan participant's benefit plan for the covered services you provide as a non-participating provider. This is because of a qualifying condition. By this form, you agree to accept rules and fee schedules that apply to participating providers for this episode of care. Payment under this agreement, together with any copayment, deductible or coinsurance for which the plan participant is responsible under the plan is payment in full for the covered service. You will not seek to recover additional payment from the plan participant or us in excess of payment in full, regardless of whether such amount is less than your billed or customary charge. If applicable, you will make referrals for services including laboratory services, to network providers which can be found at <a href="http://quartzalign.com/providers">quartzalign.com/providers</a></p>			
Signature of Physician/Facility		Date	

CONFIDENTIALITY NOTICE: The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties.

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Disclaimer: Quartz Align is powered by Brighton Health Plan Solutions, LLC, the company accredited by URAC for Health Utilization Management.