What is Transition of Care?
Transition of care coverage allows you to continue to receive services for specified medical and behavioral conditions that have been pre-certified or approved by a health care professional who do not participate in the Land of Lincoln Health (LLH) network until the safe transfer of care to a participating doctor or facility can be arranged. You must apply for Transition of Care at enrollment or with a change in your LLH medical plan, but no later than 30 days after the effective date of your coverage.

What is Continuity of Care?
Continuity of Care allows you to receive services at in-network coverage levels for specified medical and behavioral conditions for a defined period of time when your health care professional leaves the LLH network and there are solid clinical reasons preventing immediate transfer of care to another health care professional. If your health care professional is leaving the LLH network, you must apply for Continuity of Care within 30 days of the health care professional’s termination date.

How Does Transition of Care/Continuity of Care Work?
You must already be under treatment for the condition identified on the Transition of Care/Continuity of Care request form. If approved, Transition of Care/Continuity of Care coverage applies only to the treatment of the medical or behavioral condition specified and the health care professional identified on the request form.

If the Transition of Care/Continuity of care is approved for medical or behavioral conditions and your provider is in-network, payment will be made according to the in-network provisions as determined LLH.

If your provider is out of network and you choose to continue care out of network beyond the time frame approved by LLH, you must follow your plans out of network provisions.

If your provider is not in any network associated with LLH, the provider must apply for temporary coverage (single case agreement).

The availability of Transition of Care/Continuity of Care coverage does not guarantee that a treatment is medically necessary, nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, medical necessity determination and formal pre-certification may still be required for a service to be covered.

How Do I Apply for Transition of Care/Continuity of Care?
Transition of Care requests must be submitted in writing to:

Land of Lincoln Health  
ATTN: Transition/Continuity of Care  
222 S. Riverside Plaza  
Suite 1900  
Chicago, IL 60606  
Phone: 1-844-674-3845 Fax: 1-866-289-4033

Using the Transition of Care request form, at the time of enrollment or with a change in your LLH plan, or whenever your health care provider leaves the LLH network, but no later than 30 days after the effective date of your coverage.

After receiving your request, LLH will review and evaluate the information provided and will send you a letter informing you whether your request has been approved or denied. Any denials will include information on appealing the decision.

What is the time frame allowed for transitioning to a new participating health care professional?
If LLH determines that transitioning to a participating health care professional is not recommended or safe for the conditions that qualify, services by the approved non-participating health care professional will be authorized for a specified period of time (usually 90 days) or until care has been completed or transitioned to a participating health care professional, whichever comes first.

Examples of acute medical conditions that may qualify for Transition of Care/Continuity of Care include, but are not limited to:

- Pregnancy in the second or third trimester at the time of the effective date of coverage or time of the health care professional’s termination as a plan participant.
- Pregnancy is considered “high risk” such as early delivery (3 weeks) occurred in previous pregnancy, patient has had/has gestational diabetes; pregnancy induced hypertension, multiple inpatient admissions during this pregnancy; mother’s age is > 35 years old.
- Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction.
- Trauma.
- Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant.
- Recent major surgeries still in the follow-up period (generally 6 to 8 weeks).
- Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions, etc. For the purpose of this policy, “active treatment” is defined as a doctor visit or hospitalization with documented changes in a therapeutic regimen within 21 days prior to the plan effective date or your health care professional’s termination date as a plan participant.
- Hospital confinement on the plan effective date (only for those plans that do not have extension of coverage provisions).
- Behavioral health conditions during active treatment.
**Land of Lincoln Health**

**Transition of Care/Continuity of Care Request Form**

Transition of Care **must be applied for** at enrollment or with a change in your Land of Lincoln Health plan. Enrollment into a transition of care plan must be made no later than 30 days after your effective date of coverage.

Transition of Care allows you to continue to receive services for specified medical and behavioral conditions for a defined period of time with health care professionals that do not participate in the Land of Lincoln Health network until safe transfer of care to a participating doctor or facility can be arranged.

Continuity of Care allows you to receive services at in-network coverage levels for specified medical and behavioral conditions for a defined period of time when your health care professional leaves the Land of Lincoln Health network and there are solid clinical reasons preventing immediate transfer of care to another health care professional.

After receiving the Transition of Care/Continuity of Care request form, Land of Lincoln Health will, within 10 days of receipt, review and evaluate the information provided and send a letter informing you whether your request is approved or denied. A denial will include information on appeals.

- New Land of Lincoln Health enrollment (Transition of Care applicant)
- Existing Land of Lincoln Health member whose doctor/provider terminated (Continuity of Care applicant)

**HOW DO I KNOW IF I AM ELIGIBLE FOR TRANSITION OR CONTINUATION OF CARE BENEFITS?**

- Read and complete SECTION 1 of the application when applying for either Transition or Continuation of Care
- If you answer YES to even one question in SECTION 1, you may be eligible for either Transition or Continuation of Care
- If you answered NO to every question, you are NOT eligible for Transition or Continuation of Care benefits. If you need to locate a new doctor/provider due to your doctor no longer participating in the Land of Lincoln Health network, you can visit us online at [www.landoflincolnhealth.org/find-a-doctor](http://www.landoflincolnhealth.org/find-a-doctor) or call Member Services at the number listed on the back of your health insurance ID card.

**HOW DO I APPLY?**

- Complete SECTION 2 if you answered YES to at least one question in SECTION 1
- Make sure you sign the authorization to release records in SECTION 2
- Ask your doctor/provider to sign SECTION 3 of the application
- If you are receiving care from more than one doctor/provider, each one must fill out SECTION 3
- Mail or fax the completed application along with all relevant medical records to the address or fax number listed on the back side of this application **30 days before your effective coverage date** with Land of Lincoln Health.
- If your application is submitted **after the 30th day of your effective coverage date, you will not be eligible for the Transition of Care service.**
- Continuation of Care eligibility is based on the qualifying events listed in SECTION 1 and not on your effective coverage date

**SECTION 1- TO BE COMPLETED BY APPLICANT**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you in your 2nd or 3rd trimester of pregnancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you pregnant and has your doctor informed your that this is a moderate or high-risk pregnancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you undergoing treatment for symptomatic AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you undergoing treatment for severe end-stage kidney disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you currently receiving treatment for an acute condition or trauma?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you receiving treatment as a result of recent major surgery?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you would like to be considered for mental health and substance abuse services, please contact Behavioral Services at 800.753.5456
### Section 2 – To Be Completed by Applicant

<table>
<thead>
<tr>
<th><strong>Member Name</strong></th>
<th><strong>SS#</strong></th>
<th><strong>-</strong></th>
<th><strong>Plan Effective Date</strong></th>
<th><strong>Member ID#</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address</strong></td>
<td><strong>City</strong></td>
<td><strong>-</strong></td>
<td><strong>State</strong></td>
<td><strong>Zip Code</strong></td>
</tr>
</tbody>
</table>

**Home Phone** | **Work Phone** | **Cell Phone**

**Patient Name** | **Patient SS#** | **Patient DOB**

**Patient Relationship to Subscriber** (dependent, self, spouse etc.)

<table>
<thead>
<tr>
<th><strong>Employer Name</strong></th>
<th><strong>Address</strong></th>
<th><strong>City</strong></th>
<th><strong>State</strong></th>
<th><strong>Zip</strong></th>
</tr>
</thead>
</table>

**Are You Currently Covered By:**
- [ ] Medicare
- [ ] Medicaid

**Are You Currently Covered By Other Insurance?**
- [ ] Yes
- [ ] No

*If Yes, What Insurance Company?*

---

**Authorization to Release Records:**
I authorize all physicians and other health professionals or institutions to provide Land of Lincoln Health with information concerning medical care, advice, treatment or supplies for the patient named above. The information will be used to determine the patient’s eligibility for Transition or Continuation of Care benefits under their plan.

Patient Signature

Parent or Guardian Signature if Applicant is a Minor

---

**Physician’s Office:** Fill out the entire section below in its entirety before submitting to Land of Lincoln Health. Please print.

### Section 3 – To Be Completed by Physician or Healthcare Professional Currently Treating Patient Condition/Illness

<table>
<thead>
<tr>
<th><strong>Physician Name:</strong></th>
<th><strong>Physician Lic#:</strong></th>
<th><strong>Contact Number:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong></td>
<td><strong>City</strong></td>
<td><strong>State/Zip</strong></td>
</tr>
</tbody>
</table>

**Date of Patient Last Visit:**

**Next Scheduled Appointment:**

**Frequency of Visits:**

**Diagnosis:**

**Expected Length of Treatment:**

**If Maternity, Expected Date of Delivery:**

**Is Treatment for a Previous Injury or Chronic Condition?**
- [ ] Yes
- [ ] No

**Current Treatment and Comments. Please Be as Detailed as Possible**

**Physician Signature**

**Date**

---

### Section 4 – For Land of Lincoln Health Internal Use Only

<table>
<thead>
<tr>
<th><strong>Care Coordinator</strong></th>
<th><strong>Transition of Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Approved</td>
</tr>
<tr>
<td></td>
<td>[ ] Denied</td>
</tr>
</tbody>
</table>

**Continuation of Care**
- [ ] Approved
- [ ] Denied

**Coordinator: Please Submit Detailed Comments Below**

**Signature of Care Coordinator**

**Date**

---

**Transcare_LLH_2015**

Page 2 of 2