Transition of Care Form

Please answer each question. Incomplete forms will be returned to you for completion and may delay the decision-making process.

Employee Name:	Alternate Member Number:
Email address:	
Work Phone:	Home Phone/Cell Phone (include area code):
Home Street Address:	

City	State	Zip

Patient's Name (if different from above)	Patient's ID
Patient's Date of Birth	Relationship to Employee (Spouse, Dependent)

1. Is the patient pregnant? ☐ Yes ☐ No
   a. If yes, what is the due date? Date: ____________________
   b. Is the pregnancy considered high risk? (e.g., multiple births, gestational diabetes?) ☐ Yes ☐ No
   c. Is the patient currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No
2. Is the patient scheduled for surgery or hospitalization on his/her effective date with MedCost? ☐ Yes ☐ No
3. Is the patient involved in a course of chemotherapy, radiation therapy, cancer care or terminal care? ☐ Yes ☐ No
4. Is the patient receiving treatment as a results of a recent major surgery? ☐ Yes ☐ No
5. Is the patient receiving dialysis treatment? ☐ Yes ☐ No
6. Is the patient a candidate for an organ transplant? ☐ Yes ☐ No
7. Is the patient receiving mental health/substance abuse treatment? ☐ Yes ☐ No
8. If you did not answer "yes" to any of these questions, please describe the condition for which the patient is requesting transition of care:

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9. Please complete the healthcare professional information below:

Group Practice Name:	
Provider Name:	Provider Phone (include area code):
Provider Specialty	

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Provider Office Address:		
City	State	Zip
Hospital Where Provider Practices:	Hospital Phone:	
Hospital Mailing Address:		
City	State	Zip
Reason/Diagnosis		
Date of Admission (mm/dd/yy)	Date of Surgery (if applicable)	Type of Surgery (if applicable)

10. Is this patient expected to be in the hospital within 90 days of his or her MedCost effective date? ☐ Yes ☐ No

11. Please list any other continuing care needs that may qualify for transition of care coverage. Note: if these care needs are not associated with the condition for which you are applying or transition of care, you must complete a separate transition of care form.

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I hereby authorize the above healthcare provider to give MedCost Benefit Services, LLC any and all information and medical records necessary to make an informed decision concerning my request for transition of care benefits.

Signature of Patient, Parent or Guardian ______________________ Date (mm/dd/yy) ______________________

Printed Name ______________________

Please return to: mbsmedreview@medcost.com. This can also be mailed to:

MedCost Benefits Services
Attention: Appeals Department
PO Box 25307
Winston-Salem, NC 27103-5307