TRANSITIONAL CARE FORM

SummaCare recognizes that new members may need to transition to new providers upon enrollment. The purpose of this form is to assist new members with this process in an effort to ensure that in-network providers, in accordance with our Health Services Management rules, deliver your health care services.

Please complete this form if you or a covered family member is:

- Currently undergoing treatment for a condition requiring sub-specialty involvement (i.e., cardiology, oncology, etc.)
- Pregnant
- Receiving home health care, skilled nursing facility care or durable medical equipment (i.e., wheelchair, aerosol machines, CPAP, diabetic or ostomy supplies)
- Scheduled for an inpatient or outpatient procedure or surgery

Please note that the completion of this form does not guarantee authorization for continued services. Such authorization is contingent upon services being delivered by in-network providers and in accordance with the plan rules.

Member Name: _____ Member Phone: _____
(PRINT)

SummaCare Member Identification Number, if known: _____

Primary Care Physician Name: _____ Phone Number: _____
(PRINT)

Name(s) of Specialist Physicians involved in your care (if applicable) and condition:

_____ Condition: _____

_____ Condition: _____

_____ Condition: _____

Are you receiving?

Home Health Care: Yes _____ No _____ If yes, indicate name of provider:

_____

Skilled Nursing Facility: Yes _____ No _____ If yes, indicate name of provider:

_____

Durable Medical Equipment: Yes _____ No _____ If yes, indicate name of provider and equipment received:

_____

(Over)

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Are you scheduled for any procedures or tests? Yes _____ No _____ If yes, please complete below:

Name of procedure/surgery: _____

Ordering physician: _____

Date of procedure/surgery: _____

Name of facility where procedure/surgery being performed: _____

Are you pregnant: Yes _____ No _____ If yes, please complete below:

Name of OB Provider and office location: _____

Estimated delivery date: _____

Have you been told that you are high risk? Yes _____ No _____

Return the completed form to:

Health Services Management Department
P.O. Box 3620
Akron, Ohio 44309