

Request for Transition of Care

Thank you for allowing Humana to provide your health benefits. We appreciate your business and your trust.

Our records show that when your Humana coverage begins, you or a covered family member may be receiving care from a provider who is not in your plan's network. We understand that changing providers at this time may not be possible. To help promote the appropriate care, we have a "Transition of Care" exception process. This process helps us decide whether we can temporarily authorize care from an out-of-network provider while paying the charges at the in-network benefit level.

Conditions that may qualify for Transition of Care exceptions are pregnancies beyond 20 weeks, cancer therapy, post-operative periods, dialysis, planned non-elective procedures, home health therapy, and durable medical equipment (DME) services.

To request a Transition of Care exception, please complete the form below and mail or fax it to us as shown. We can only consider requests received **within 90 days of your effective enrollment date**. Our clinical staff will evaluate your request and notify you, in writing, of our decision, within 15 days after we receive this form. Also, we may need to call you to get more information before we make our decision. Thank you for your patience while we review your request.

Please check the appropriate box for your request:

- Planned surgery or hospitalization after the effective date of your enrollment
- Home health care services you are currently receiving
- Durable medical equipment you are currently using
- Ongoing medical treatment, such as chemotherapy, dialysis, radiation, hospitalization, etc.
- Pregnancy Expected Due Date: ____/____/____ (MM/DD/YY)
- Other condition or additional comments:
(please be specific, and include the subscriber's name, ID, and patient's name on any additional pages you send)

This does not include pharmacy-related services like medications or prescriptions.

Subscriber's Full Name: (first/middle/last)		Birth Date: (mm/dd/yy) / /	
Patient's Full Name: (first/middle/last)		Birth Date: (mm/dd/yy) / /	
Address:			
City:		State:	Zip:
Home Phone: ()		Work/Cell Phone: ()	
Effective Date of Enrollment: (mm/dd/yy) / /		Employer/Group Name:	
Member ID Number of Subscriber:			
Physician: Name/Phone Number of Primary Care Physician:			
Name/Phone Number of Doctor Handling Treatment:			
Treating Doctor's Specialty:			

Please mail this completed form to: Clinical Intake Team
Humana Inc.
PO Box 400029
San Antonio, Texas 78229

Or fax form to: 1-800-266-3022

