Medical Transition of Care Benefit Request

Transition of Care, also referred to as treatment in progress, is a benefit that allows new subscribers and covered dependents to receive medical care by non-participating providers at their in-network level of benefits for treatment of an acute injury or illness. Transition of Care is short term and not intended to replace the regular provisions of the subscriber's Horizon BCBSNJ health insurance plan.

Examples of conditions that may meet Transition of Care guidelines

- Women who are pregnant and have had their first prenatal visit prior to the effective date of coverage
- Acute fracture victims
- Heart attack victims under acute care
- Cancer patients currently undergoing approved chemotherapy or radiotherapy treatment protocols
- Diagnosed terminal illness where life expectancy is less than 60 days
- Members hospitalization at the time of eligibility
- Surgery scheduled in the month prior to coverage effective date

Examples of conditions that may NOT meet Transition of Care guidelines

- Routine examinations, vaccinations and health assessments
- Stable but chronic conditions, (e.g., diabetes, hypertension, allergies, arthritis)
- Minor illnesses, (e.g., colds, sore throats, ear infections, bronchitis, strains, sprains)
- Long term management of cancer, dialysis, transplants, etc.

Transition Benefit Enrollment Process

All requests for transition care must be submitted in writing. The form on the following page must be completed and signed by you and your treating doctor. A separate form must be completed for each condition/doctor.
You may submit completed and signed forms, along with all supporting documentation, to us by email to HBCBSNJTransitionalBenefitsCoordinator_@HorizonBlue.com or by mail to

Horizon BCBSNJ Transitional Benefits Coordinator, PP- 12T
PO Box 420
Newark, NJ 07101-0420

Transition Review Process

1. Upon receipt of a completed and signed *Medical Transition of Care Request Form*, the Medical Department will review and evaluate the information.

2. Based upon this initial information, the subscriber will be informed, in writing, of the decision in one of three ways:
    a. Request for transition care approved for a specific period of time or a specific number of visits.
    b. Request for transition care denied.
    c. Request for additional information needed before a final decision can be made.

Eligible care rendered by non-participating providers after the transition period has expired will be paid at the out-of-network benefit level.

RESET

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To be Completed by the Subscriber/Patient

Subscriber Name _____ DOB: _____

Address _____

Home Phone # _____ Work Phone # _____

Horizon BCBSNJ Member ID # _____ Horizon BCBSNJ Group # _____

Effective Date of Coverage _____

Patient Name (if different than subscriber) _____ DOB _____

Address (if different than subscriber's) _____

Relationship to Subscriber _____

Prior Insurance Carrier Name_____Policy/ID # _____

Did the prior carrier authorize treatment for the patient's condition/illness/injury? ☐Yes ☐No

Authorization # _____ Authorized Dates of Treatment _____

Please provide a copy of the Authorization Approval or Determination Letter from the Prior Insurance Carrier.

Patient/Guardian Signature _____ Date _____

By signing here, I hereby authorize the doctor noted to provide Horizon BCBSNJ or any affiliated Horizon BCBSNJ company with any and all information including medical records relating to the above diagnosis and treatment plan for Horizon BCBSNJ use in evaluating my request for Transition Care Benefits. This authorization is valid six months from the date signed above.

To be Completed by the Treating Doctor

Name _____ NPI _____

Practice Name _____ Practice NPI/TIN _____

Address _____

Phone _____FAX _____ Email _____

ICD-10 Diagnosis Codes and Description of condition/illness/injury _____

Date condition/illness/injury was diagnosed _____

Length of time patient was treated for this condition/illness/injury _____

Please provide a copy of the pertinent Medical Record information for your treatment of this patient.

Doctor's Signature _____ Date _____

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services
Call Member Services at **1-844-498-9393** (TTY **711**) **or the phone number on the back of your member ID card**, if you need the free aids and services noted above and for **all other Member Services issues.**

Filing a Section 1557 Grievance
If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to:

Horizon BCBSNJ
Civil Rights Coordinator
PO Box 820
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Language assistance
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-498-9393** (TTY **711**).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-498-9393**（TTY 711）.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-844-498-9393 (TTY 711)번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-844-498-9393** (TTY **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-844-498-9393** (TTY **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-498-9393** (TTY **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-498-9393** (TTY **711**).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-**844-498-9393** (رقم هاتف الصم والبكم 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-498-9393** (TTY **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-498-9393** (телетайп **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-498-9393** (TTY **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-844-498-9393 (TTY **711**) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-844-498-9393** (TTY **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-498-9393** (ATS **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-844-498-9393 (TTY **711**).