CONTINUITY/TRANSITION OF CARE REQUEST FORM

Fill out the form completely, do not leave any blanks. Use "N/A" if the question doesn't apply to you

Use a separate form for each family member who need to have care transitioned to another provider

Subscriber Information

Employer _____ Subscriber ID, if issued _____

Name *(First and Last)* _____ Date active with New Network _____

Patient Information

Patient Name *(First and Last)* _____ Relation to Subscriber ☐Spouse ☐Son ☐Daughter ☐Other _____

Preferred Phone Number _____

Date of Birth _____ Gender _____

Allergies _____

Are you a new enrollee in this plan? ☐ Yes ☐No

If Yes, please, please fill in the green-shaded areas a) and b)
If No, skip to the yellow shaded area C

A) Name of terminating insurance plan: _____ B) Type of terminating plan: ☐HMO ☐ PPO ☐ EPO ☐ Other _____

C) Provide the name of your doctor or hospital canceling your care or terminating with network:

Diagnosis (Include pertinent history and physical findings):

1. Do you have an upcoming appointment to see a specialist? ☐ Yes ☐ No – If yes, please provide the applicable information.

Specialist Information

Specialist type	Provider Name (Last, First)	Provider Address	Provider Phone #	Date of Next Office Visit	Reason
Obstetrician for pregnancy					
Due Date: (MM/DD/YYYY)			Hospital for delivery:		
Applied behavior analysis (ABA) provider					
Blood or cancer specialist					
Heart specialist					
Infectious disease specialist					
Kidney Specialist					
Licensed clinical psychologist					
Licensed clinical social worker (LCSW)					
Licensed marriage and family therapist (LMFT)					
Lung Specialist					
Neurologist					
Orthopedic Specialist					
Psychiatric/ Mental health nurse practitioner (PMHNP)					
Psychiatrist					
Other (Please be specific)					

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2. Are you currently receiving any of the following services? ☐ Yes ☐ No – If yes, please provide the applicable information below:

Services Information

Services	Facility	Company	Provider Name	Provider Address	Phone #
Applied behavior analysis (ABA)					
Clinical Laboratory					
Dialysis					
Home therapy					
Intensive outpatient					
IV Medication/chemotherapy					
Medical equipment					
Medication assisted treatment					
Medication management for a behavioral health condition					
Occupational therapy					
Organ or stem cell/bone marrow transplant					
Oxygen					
Partial hospitalization					
Physical therapy					
Psychological testing					
Radiation therapy					
Rehav treatment					
Residential care					
Speech therapy					
Transcranial magnetic stimulation					
Other (Please be specific)					

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No – If yes, please provide the applicable information below.

Procedure Information

Date Scheduled _____

Type of surgery/procedure _____

Name of physician performing surgery/procedure _____

Hospital Name _____

Hospital/ Facility Name _____

4. Requested start date for transition of care/continuity of care

Date (MM/DD/YYYY)

5. Other Needs

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I authorize BRMS to leave confidential information on my voicemail at the number(s) provided on the form above. Please check all that apply:
☐Home ☐Cell ☐Work ☐ Do NOT leave confidential information on my voicemail

Signature Required

Signature of patient if age 18 or over		Printed Name *(First and Last)*	
		Date (MM/DD/YYY)	
Signature of parent or guardian if patient is under the age of 18		Printed Name	
		Date (MM/DD/YYY)	

Continuity/Transition of Care Request Form: Authorized Disclosure Form:

Patient Name *(First and Last)*		Date of Birth	
Signature of patient if age 18 or over		Printed Name	
		Date (MM/DD/YYY)	
Signature of parent or guardian if patient is under the age of 18		Printed Name	
		Date (MM/DD/YYY)	

Submission Information

For additional information, please contact your dedicated BRMS Customer Support #: 800-368-0767

Submit this form to:
Email: **ManagedCare@BRMSonline.com**
Secure Fax: **916-467-1403**
Mail:
BRMS
Attn: Medical Management
80 Iron Point Circle Suite 200
Folsom CA 95630