TRANSITION OF CARE FORM

Please fax completed form and all supporting documentation to

410-801-5701

Welcome to Alterwood Advantage! We want to assist you with transitioning to a participating network provider.

Please complete this *Transition of Care Form* with your current provider and return the form to the Alterwood Advantage Health and Quality Management department. Completing this form will help us make the transitionas seamless as possible.

If you need to speak with a Health and Quality Management Representative, please call 667-262-9429 or toll free at 1-866-274-3265. **For assistance in selecting a new, par provider, members may also call 667-262-9412 or tollfree at 1-866-675-3944.**

Please check the appropriate priority (Standard or Expedite):

□ Standard

If member is inpatient, please select the proper review type**:** □ Notice of Current Admission □ Pre-Service

□ Expedited *(pre-service only; post-service requests do not qualify for expedited review)*

I certify that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.

Provider Signature Required: _____

Member Information

First Name:	Last Name:	Date of Birth:	Member ID:

Provider Information: Please complete all sections in full.

	Requesting Provider	**Servicing Provider**
Name:		
NPI:		
Address:		
Phone:		
Fax:		

This authorization does not guarantee payment of claim. All authorizations are subject to eligibility requirements and benefit plan limitations. ***Services are not considered authorized until Alterwood Advantage issues an approval.*** For a list of services that require PA or if you need to speak to a Utilization Management Representative, please call 667-262-9429 or toll free at 1-866-274-3265.

ALTERWOOD HEALTH
Quality Care. Better Health.

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Facility Information: Please enter the information for where services will be rendered.

Name:	
NPI:	
Address:	
Phone:	
Fax:	

Services Previously Approved: Please check the appropriate service

□ Physical Therapy	□ Occupational Therapy	□ Speech Therapy	□ Cardiac Rehab
□ Home Health	□ Durable Medical Equipment (DME)		□ Radiology
□ Scheduled Inpatient	□ Transplant	□ Other (please specify):	

Start Date:	End Date:	Number of Sessions/Visits:
Frequency (if applicable):		
Diagnosis Code(s):		
Diagnosis Code Description(s):		
CPT/HCPCS Code(s):		
CPT/HCPCS Code Description(s):		
Previous Health Plan:		
Previous Authorization #:		

If previous authorization approval letter is available, please provide a copy of this with your request

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