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 transition as 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). Requests without a selected priority will be processed as Standard.

□ 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.

Physician Signature Required: _____

Member Information

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

Servicing Provider Information: Please enter the information for the servicing provider group/supplier.	
Provider Name:	
Group Name:	
Group NPI and Tax ID:	
Address:	
Contact Name & 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.

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Facility Information: Please enter the information for where services will be rendered.	
Name:	
NPI and Tax ID:	
Address:	
Contact Name & Phone:	
Fax:	

Services Previously Approved: Please check the appropriate service. Note: Out of Network providers require authorization for all services that will be billed to Alterwood Advantage.

□ 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:
Place of Service (POS):		
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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