TRANSITION OR CONTINUITY OF CARE

- **Transition of Care** is for members who are new to Western Health Advantage.
- **Continuity of Care** is for existing members whose provider terminates with Western Health Advantage.

What is Continuity of Care?

In certain circumstances (below), you may temporarily continue care with a physician who is not part of WHA's network (a "Non-Participating Provider"). If you are being treated by a provider who has been terminated from WHA's network, or if you are a new member who has been receiving care from a Non-Participating Provider, you may continue care with that provider if you meet the transition or continuity of care requirements explained below.

Transition or Continuity of Care Requirements

In order for you to be eligible for continued care, the Non-Participating Provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis.

- An acute condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition: A serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the member and the terminated provider or Non-Participating Provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled member.
- A pregnancy: Care will be continued for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness: An incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness.
- Performance of surgery or other procedure that has been authorized by WHA (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days, including receipt of postoperative care related to the procedure or surgery.
- Undergoing a course of institutional or inpatient care from the provider or facility on our form.

Note About Providers

WHA and/or the medical group may require the Non-Participating Provider to agree to WHA's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not comply with these contractual terms and conditions, you may not be eligible to continue care with that provider.

How do I submit this form?

Please complete the entire form, sign it and return it via mail, fax or in-person delivery:

BY MAIL:	Western Health Advantage 2349 Gateway Oaks Drive, Suite 100 Sacramento, CA 95833
BY FAX:	Western Health Advantage Attn: Clinical Resources 916.568.0278
TO DELIVER IN PERSON:	Western Health Advantage 2349 Gateway Oaks Drive, Suite 100 Sacramento, CA 95833

If you have questions about Western Health Advantage's continuity of care policy, please call WHA Member Services Department at 888.942.4777; 711 TTY. Available 8 a.m. and 8 p.m. seven days a week (October–March), and 8 a.m. and 8 p.m. Monday–Friday, (April–September), excluding holidays.

Transition of Care or Continuity of Care Request Form

Mail to: Western Health Advantage, Attn: Clinical Resources
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0278
Questions? 888.942.4777 toll-free | 711 TTY

If you are currently receiving treatment and (i) a new WHA member or (ii) an existing WHA member whose physician has terminated with WHA, you may request to temporarily remain with your existing physician. Please see the cover letter included in this document for more information about what transition and/or continuity of care is and if you may be eligible.

To request transition or continuity of care, complete this form for each physician you want to retain. If you do not have a qualified transition or continuity of care issue, you may still request assistance in changing to WHA providers by using this form. Turn this form into WHA within 30 days of enrolling (if new) or of when your physician terminated with WHA. WHA will let you know if you qualify for transition or continuity of care.

REQUEST IS FOR:

❑ **Continued Care with Current Specialist OR**

❑ **Assistance with Changing Specialist/Provider**

Section I — PATIENT, PHYSICIAN AND TREATMENT INFORMATION

First Name _____ Last Name _____ MI _____

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth_____ Diagnosis _____

WHA Member ID#_____ WHA Effective Date_____

WHA Primary Care Physician _____

WHA Medical Group _____

Previous Health Insurance Carrier_____

Out-of-Network Providers

Requested Specialist Name _____

Phone _____ Specialty _____

Specialist Address _____ Suite # _____

City _____ State _____ Zip _____

Is patient pregnant? ❑ YES ❑ NO If yes: Due Date _____

Delivering Hospital _____

Date of initial diagnosis/treatment _____

Is patient currently receiving treatment? ❑ YES ❑ NO

Date of next scheduled treatment/appointment _____

Current treatment/need (provide details, use separate sheet if necessary) _____

Section II — SIGNATURE REQUIRED

I authorize the medical providers listed above to disclose all medical records to Western Health Advantage (WHA) for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after WHA completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and WHA are required under state and federal law to keep my medical information confidential. I understand that WHA will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

Patient Signature _____ Date _____