# 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:**

Secure Fax: **916-467-1403**
Mail:
**BRMS**
**Attn: Medical Management**
**80 Iron Point Circle Suite 200**
**Folsom CA 95630**