Sanford Group Health
Transition of Care Request Form

PO Box 91110
Sioux Falls, SD 57109
Fax: (605) 328-7001
um@sanfordhealth.org

SANFORD HEALTH PLAN

We understand and recognize the importance of your relationship with your provider. If your provider will no longer be in the network effective January 1, 2016 and you are currently receiving services for a specific medical condition, please complete the following form. The form can be completed for the following:

- You are in your second or third trimester of your pregnancy
- You have a surgery already scheduled
- You are receiving cancer treatment or transplant services
- You are receiving services where it would be deemed harmful to transition at this point of treatment
- You are undergoing active treatment for a disabling, chronic or acute medical condition; or have a life threatening mental or physical illness
- You have a physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year, or can be expected to result in death

This request form is not intended for services considered routine, such as yearly physicals.

Once this form is completed and sent to Sanford Health Plan, we will review the request and send a written notice of determination. Please fill out a separate form for each condition. Completion of this form does not guarantee authorization or payment for the requested services. Forms can be faxed to (605) 328-7001 or sent to the address above.

Employee Name: _____

Last 4 Digits of Social Security Number: _____Date of Birth: _____/_____/_____

Address: _____ City/State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

Patient's Name: _____ Date of Birth: _____

Relationship to Employee: _____ Self _____ Spouse _____ Dependent Child

Describe health condition: _____

_____

_____

_____

When did condition begin? _____

Facility Requested: _____ Location: _____

Physician(s) currently involved (list names): _____

_____

Address: _____ City/State: _____ Zip: _____

Date of last visit: _____ Frequency of visits: _____

Describe current treatment or proposed surgery or treatment: _____

_____

_____

_____

Expected length of treatment or date of surgery: _____

_____

_____

Primary care physician name: _____

Physician's Address: _____ City/State: _____ Zip: _____

IMPORTANT: In order to determine your transition of care needs, we may have to review your medical records. Complete the following information below to provide Sanford Health Plan with the authorization required to review your health information.

I understand that I may revoke this authorization at any time by written notification. However, the revocation is not valid if:

- Action was previously taken in reliance on this authorization; or
- This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

This authorization expires:

☐ The following date: _____/_____/_____ (or one year from the date of signature if no date entered)
☐ When the following event occurs: _____

Please read and sign:

As a member under a Sanford Health medical insurance policy, I have read and understand this form. I hereby authorize Sanford Health Plan to obtain my entire health record (including all medical and prescription drug information) in writing or through verbal communication with the current or past medical providers I have indicated on this form. I understand that this authorization is voluntary. Unless allowed by law, this form will have no effect on my eligibility of benefits, nor does it affect my ability to obtain treatment or receive payment. With my signature below, I hereby authorize the use or disclosure of my individually identifiable health information for the services described on this form. I am entitled to a copy of this authorization form. I understand that completion of this form does not guarantee authorization or payment for the requested services.

_____

Signature of Patient or Guardian Date Signed

_____

Name of Personal Representative (if applicable) Relationship to Member

_____

Witness/Organization Representative Date

For Internal Use Only

Date requested: ____/____/____
Name of requestor: _____
Department: _____
Information needed by: ____/____/____
Date sent: ____/____/____
Name of sender: _____
Department: _____