TRANSITION OF CARE/CONTINUITY OF CARE REQUEST FORM

GENERAL INFORMATION ABOUT TRANSITION OF CARE ASSISTANCE

What is Transition of Care/Continuity of Care? Transition/Continuity of Care coverage allows you to continue to receive ongoing services for a 90-day transition period when moving between health plans. When you enroll with Zing Health, we require that you notify us which services are ongoing so we can ensure there is no service disruption. You must apply for Transition of Care coverage at enrollment or no later than 30 days after the effective date of your coverage.

How Transition of Care/Continuity of Care Works:

- You must already be under treatment and receiving services for the condition identified on the Transition of Care/Continuity of Care request form.
- If Transition of Care/Continuity of Care is approved for medical or behavioral conditions, you will receive the in-network level of coverage for treatment of the specific condition by the health care professional for a defined time. If your plan includes out-of-network coverage and you choose to continue care out of network beyond the time approved by Zing Health, you must follow your plan's out-of-network provisions. This includes any pre-authorization requirements and any cost sharing and/or balance billing that may occur from the out-of-network provider.
- Transition of Care/Continuity of Care coverage applies only to the treatment or service identified on the form. All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage levels.

If one or more of the above situations apply to you and you would like to see if you are eligible to participate in transition of care, please:

Call the Member Services number on the back of your ID card, and they will assist you with understanding how you should complete your form. Member Services will also assist you in locating a network doctor. Our Health Services department will determine whether you qualify for a transition of care. Send this completed request form to Zing Health in any of the ways listed below:

- Fax to Zing Health, Health Services Department at 844-946-4458.

- Mail to Zing Health, Attention: Health Services Department, 225 W. Washington St., Suite 450, Chicago, IL 60606.

You will be notified in writing of approval or denial of your transition of care request.

To help ensure that your care is not interrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care and your care requires prior authorization or is being performed by an out of network provider. If your doctor is not part of our network and you need assistance locating a network doctor, contact Member Services at the number below for assistance with a provider network.

Member Services

866-946-4458 (TTY: 711)

8 a.m. to 8 p.m. Monday through Friday (April 1 - September 30)
8 a.m. to 8 p.m. 7 days a week (October 1 - March 31)

Transition of Care/Continuity of Care Request Form

Fill out the form completely. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Member Name	
Zing ID Number	
Date of Birth	
Home Phone	
Cell Phone	
Email Address	

1. Is the patient currently receiving treatment for an acute condition? ☐ Yes ☐ No
2. Is the patient scheduled for surgery or hospitalization after your effective date with Zing Health? ☐ Yes ☐ No
3. Is the patient currently receiving treatment for an acute condition? ☐ Yes ☐ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Zing Health? ☐ Yes ☐ No
5. Is the patient receiving chemotherapy, radiation therapy, or other cancer therapy? ☐ Yes ☐ No
6. If you did not answer "Yes" to any of the above questions, please describe the services or treatments that are in progress that would need to be continued for continuity of care? ☐ Yes ☐ No

Service or Treatment Name	CPT Code

Please complete the healthcare professional information request below.

Health Care Professional Name	Health Care Professional Phone #
Health Care Professional Specialty	Health Care professional NPI#
Health Care Professional Address	
Reason Diagnosis	

Date(s) of Admission (MM/DD/YYYY)	Date of Surgery (MM/DD/YYYY)	Type of Surgery
Treatment Being Received and Expected Duration		

I hereby authorize the above provider to give Zing Health any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care Benefits under a Zing Health Benefit Plan. I understand that I am entitled to a copy of this authorization form. I also authorize Zing Health to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

❑ Home ❑ Cell ❑ Email ❑ Do not leave confidential information on my voice mail

Signature of Patient	Date (MM/DD/YYYY)