Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

Applies to:

JPMorgan Chase & Co.
U.S. Medical Plan administered by Aetna

Here's the form you requested for transition/continuity of care coverage from Aetna. If we approve your request, Aetna will cover ongoing care at the in-network benefit level from

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition/continuity of care coverage.
You'll find answers to commonly asked questions about transition/continuity of care coverage on the other side of this form. You should read them before filling out this form.

Transition/Continuity of care coverage does not apply if your provider is in Aetna's network (participating). The online provider search directory is found on the Aetna webpage. It can tell you if your doctor is in the network or help you find a participating provider for your Aetna plan at **My Health > Benefits Enrollment > go to Aetna site**. You can also call us at the phone number on your ID card.

How to complete the form and get it to us

Step 1: Fill out these sections:

1. Section 1 (Group or employer information).
2. Section 2 (Subscriber and patient information): Plan information is on the front of your ID card. If you don't yet have your Aetna ID card, you can access your ID cards on the Aetna member website, login and select the "View Member ID cards" link under the Plans section on the left. You may also call Member Services at 1-800-468-1266 for assistance.
3. Section 3 (Authorization): Read the authorization, then sign and date the form.

Step 2: Give the form to the **doctor/health care provider** to complete **Section 4 on page 4**, including the diagnostic and treatment information requested on **page 5**.

Step 3: **Fax** the completed form to us for review. You can mail the completed form to the address listed on your ID Card. You should complete one form for each health care provider.

Fax medical requests to 1-860-754-2609 or

Mail medical request to: 699 South Keeneland Dr. Richmond, KY 40475-3235, or

7777 Market Center Ave., Suite E, El Paso, TX 79912-8411

Phone: (915) 877-7032 (Needed for UPS shipping)

Or send via email to: Aetna-JPMC@aetna.com

Fax mental health/substance abuse requests to 1-888-463-1309

Be sure to complete all fields on pages 4 and 5. *Your request will be answered faster that way.*

Transition/Continuity of care coverage questions and answers

Q. What is transition/continuity of care (TOC/COC) coverage?

- **For new members**:
  TOC coverage is temporary. You can get TOC when you become a new member of a medical benefits plan or change your plan, and you are being treated by a doctor who:
  - Is not in the plan's network; or

  TOC coverage can also apply when your doctor leaves the plan's network or changes network status or if certain laws or regulations require coverage. Approved TOC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

  TOC coverage is only for the requested doctor. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

- **For existing members**:
  COC coverage can also apply when your doctor or facility leaves the plan's network or changes network status or if certain laws or regulations require coverage. Approved COC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

  If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?

A. An active course of treatment means you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course-of-treatment examples may include, but are not limited to members who:

- Are pregnant and has begun a course of treatment (including prenatal care) for the pregnancy from the obstetrician (OB) or facility.
- Are undergoing a course of treatment for a serious and complex condition from the provider or facility, such as chemotherapy or radiation therapy.
- Are or was determined to be terminally ill (if the individual has a medical prognosis that the individual's life expectancy is 6 months or less) and is receiving treatment for such illness from such provider or facility.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance use. (The member must have had at least one treatment session within 30 days before the status of the member or the participating health care provider changed.)
- Have an ongoing or disabling condition that suddenly gets worse.
- May need or have had an organ or bone marrow transplant.
- Are scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

To be considered for TOC/COC coverage, treatment must have started **before** the enrollment or re-enrollment date, or ***before*** the date your doctor or facility left the health plan's network, or ***before*** the date a doctor's or facility's network status **changed**.

Q. Do I need to complete a form for each provider that I am requesting TOC/COC for?

A. Yes, a separate form is required for each provider.

Q. What other types of providers, besides doctors, can be considered for TOC/COC coverage?

A. This includes health care professionals such as physical therapists, occupational therapists, speech therapists and agencies that provide skilled home care services, such as visiting nurses. TOC/COC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks or when a participating facility terminates from the network.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for TOC/COC coverage?

A. To be approved for TOC/COC, the procedure or service must be a covered benefit under the terms of your plan. **For providers that leave the network:** As part of the Federal No Surprises Act, your doctor must accept the terms outlined on the COC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're receiving treatment, you may still be able to visit your PCP, even if he/she leaves the network.

Q. How long does TOC/COC coverage last?

A. Usually, TOC/COC coverage lasts 90 days, but this may vary based on your condition (for example, pregnancy). We will tell you if your TOC/COC coverage request is approved and how long the coverage will last.

Q. How do I sign up for TOC/COC coverage?

A. Contact the Member Services number on your member ID card. You must submit a TOC request form to the health plan:

- Within 180 days of when you enroll or re-enroll
- Within 180 days of the date the health care provider left the plan's network or within 180 days from the date on the letter notifying you of the change
- Within 180 days of a doctor's network status change

You or your doctor can call us or send in the request form.

Q. What if I have more questions about TOC/COC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC/COC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health number.

Q. How will I know if my request for TOC/COC coverage is approved?

A. We will make a decision after we receive your request. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

Disclaimers

The availability of Transition of Care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-certification may still be required for a service to be covered.

Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

☐ **Medical** ☐ **Mental health/substance use**

Please indicate above whether this request is for medical treatment or mental health/substance use treatment.

Form completed by: ☐ Member ☐ Provider

1. Group or employer information (Note: Complete a separate form for each member and/or provider.)

Group or employer's name (please print)	Plan control number(s)	Plan effective date
JPMorganChase		

2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID number	
Subscriber's address (please print)		
Patient's name (please print)	Birthdate *(MM/DD/YYYY)*	Telephone number
Patient's address (please print)	Plan type/product	
	Telephone number for patient/subscriber submitting request. (Business hours, 9 a.m. – 5 p.m.)	

Request for Transition/Continuity of Care Coverage due to:

New member: ☐ Yes ☐ No **Provider termination:** ☐ Yes ☐ No **If provider termination,** please provide the date of the letter notifying you of the provider terminating from the network and include a copy of the letter with the completed form. *(MM/DD/YYYY)*

3. Authorization

I request approval for coverage of ongoing care from the health care provider named below for treatment started before my effective date with Aetna, or before the end of the provider's contract with the Aetna network, or before the provider's network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain period of time. I give permission for the health care provider to send any needed medical information and/or records to Aetna so a decision can be made.

Patient's signature (**required if patient is age 17 or older**)	Date *(MM/DD/YYYY)*
Parent's signature (**required if patient is age 16 or younger**)	Date *(MM/DD/YYYY)*

4. Provider information (Note: Provide all specific information to avoid delay in the processing of this request.)

Name of treating doctor or other health care provider (Please print)	Tax ID number
Service Address of treating doctor or other health care provider (Please print)	
Contact name of office personnel to call with questions	Telephone number
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in Aetna's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation." Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not to seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use Aetna's network for any referrals, lab work or hospitalizations for services not part of the requested treatment. The provider completing the form may not be leaving the network but may request continuing care to be provided by a hospital that is leaving the network.

Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

Patient's name (please print)	Birthdate *(MM/DD/YYYY)*

Provider: Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY

Are you in a current course of active treatment (Reconstruction Surgery, Radiation Therapy, Immunotherapy, Targeted Agents, **OR** Chemotherapy) for Cancer with treatment initiated in the last 90 days?

☐ Yes ☐ No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next Visit Dates: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for Antibiotics, **OR** Hyperalimentation/Total Parenteral Nutrition?

☐ Yes ☐ No Treatment Start Date: (mm/dd/yyyy): _____ and Expected End Date: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a Surgeon's office and is the member within the 90 days post-operative period **OR** has the member started ~~a~~ series of surgical procedures to correct the same condition?

☐ Yes ☐ No Date of Surgery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed her first visit with an Obstetrician (OB) office?

☐ Yes ☐ No First OB Visit: (mm/dd/yyyy): _____ Expected Date of Delivery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment Start Date: (mm/dd/yyyy): _____ Last Date of Treatment: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____