MVP HEALTH CARE

SEND TO: PO Box 2207, Schenectady, NY 12301 Attn: Out-of-Plan/Prior Approval Unit

TRANSITION OF CARE BENEFITS APPLICATION

Dear MVP Subscriber:

If you have just joined MVP and you are currently under the care of a physician who is not participating with MVP, and are undergoing treatment for a life threatening, degenerative, or disabling condition you may be eligible for 60 days of Transition of Care Benefits with your non-MVP physician (90 days for Federal Employee Health Benefits program). If you are in your 2nd or 3rd trimester of pregnancy, the transitional period includes delivery and post-partum care related to the delivery.

If you are a current MVP member and your physician has left the MVP network, and you are receiving an active course of treatment, you may be eligible for 90 days of transitional care from the date your physician leaves the MVP network. If you are in your 2nd or 3rd trimester of pregnancy, the transitional period includes delivery and post-partum care related to the delivery.

To be eligible for Transition of Care Benefits, you must be enrolled in a benefit plan administered by MVP. To apply, you should complete Sections 1 and 2 of this application. Ask your current non-MVP participating Physician to complete Section 3 and provide copies of relevant medical records. If there is more than one non-MVP participating physician involved in your case, please provide a separate form for each one. You or your non-MVP participating physician should send the completed application and medical records to MVP, at the address listed above.

If MVP's Medical Director determines transitional care is medically necessary under the terms of the benefit plan, MVP will approve specific treatment, by specified non-MVP participating physician(s) for a specific period of time. It is also necessary for the non-MVP physician to agree to: 1) accept MVP's payment in full; 2) provide MVP with medical information about your care; and #3) follow MVP's policies and procedures. These services are subject to eligibility and coverage limitations at the time medical care is administered. Please refer to your Member Handbook for further details.

SECTION 1		**TO BE COMPLETED BY MEMBER**
Subscriber Name	MVP ID#:	
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name	Plan Effective Date	
Member Name	Patient's Date of Birth	
Member's Relationship to Subscriber (i.e., spouse, dependent, self)		
Are you currently covered by: Medicare Medicaid	Are you currently covered by other insurance YES NO	

SECTION 2	**TO BE COMPLETED BY MEMBER**
Is the member currently pregnant and in her 2nd or 3rd trimester of pregnancy?	YES NO
Is the member currently undergoing a course of treatment?	YES NO
Is the member currently undergoing treatment for cancer?	YES NO
Is the member undergoing treatment for a fracture?	YES NO
Has the member been hospitalized within the past six weeks?	YES NO
Has the member had surgery within the past six weeks?	YES NO
Do you have an appointment with your doctor prior to your effective date or within thirty days after?	YES NO

If you have answered YES to any of the questions, please have your non- MVP participating physician complete the rest of this form along with any pertinent medical records and return to the MVP address listed above.

If you have answered NO to all of these questions, please contact Member Services (1-888-687-6277) for assistance in identifying a network physician for an evaluation.

Authorization to release records:

I authorize all physicians and other medical professionals or institutions to provide MVP information concerning medical care, advice, treatment, or supplies for the Member named above. This information will be used to determine the Member's eligibility for Transition of Care Benefits under the new plan.

Member's Signature / Parent or Guardian's Signature if Applicant is a Minor : Date:

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Physician:

Please fill out and check the entire form for completeness before submission to MVP.

SECTION 3	**TO BE COMPLETED BY PHYSICIAN CURRENTLY TREATING CONDITION**	
Non- MVP Participating Physician Name	TAX ID #:	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If Maternity, Expected Date of Delivery	Is Treatment for an exacerbation of a previous injury or chronic condition? YES NO	
Current Treatment/Comments		
Signature of Physician	**Date**	

SECTION 4	**FOR INTERNAL USE ONLY, MVP HEALTH CARE**
Medical Director Name	Transition of Care Benefits: Approved Not Approved
Comments	
Medical Director Signature	Date