Transition-of-Care Request Form

How it works:

- You must submit the attached transition-of-care form no later than 14 days after your plan's effective date. You may submit prior to your effective date. Forms must be submitted prior to any services being rendered. Prevea360's medical management will review the information supplied and will assess whether your care qualifies for a transition-of-care authorization. Submission of this form does not guarantee authorization approval for services with out-of-network providers.

- You or your dependent will be contacted by a Prevea360 representative regarding your transition-of-care request within 7 business days. If you are not contacted within 7 business days, you should contact our Customer Care Center at (877) 232-9375.

- If your transition of care is approved, Prevea360 will facilitate the initial prior authorization, indicating any limitations or special instructions regarding the request. You will receive a written authorization letter.

Transition of Care Request Form

Please complete, sign and return this form within 14 days of your plan effective date to Prevea360:

Fax
608.252.0879

Mail
Prevea360 Health Plan
PO Box 56099
Madison, WI 53705

Employer Name:			
Employee Name:			
Enrollment Date:	*Plan Type : [ ]HMO [ ] PPO [ ]POS [ ] Other _____*		
Patient Name:		*Patient Birth Date:*	
Relationship to Patient:		*Primary Phone:*	
Patient Address:		*Work Phone:*	
		May we contact you at work? [ ]Y [ ]N	*Best Time to Reach You: [ ]morning [ ]day [ ]evening*
Description of condition and treatment in progress:			

Current Providers	*Provider 1*	*Provider 2*	*Provider 3*
Provider name:			
Location:			
Phone:			
Specialty:			
Last visit:			
Next visit:			

By signing below, you consent to having a Prevea360 representative contact you or your dependent, if applicable, regarding transition of care questions. If the care described above is for your **spouse or dependent over age 18**, a representative will contact your spouse or dependent.

Signature of policy holder **Date** **Phone number**

Spouse/Dependent's Name **Date** **Phone Number**