

TRANSITION-OF-CARE FORM – Commercial Plans

AvMed Health Plans • Nurse On Call, P.O. Box 749, Gainesville, FL 32602 • Fax 1-800-339-3554

If you have enrolled with AvMed Health Plans and require assistance with transition of your care from your previous insurance carrier and their providers, please complete this form and mail or fax it to the address below. This information is NOT used to determine eligibility – it is to assist us in arranging a smooth transition of your medical care to AvMed providers. To assure coverage, any planned or on-going treatment must be coordinated and approved by AvMed prior to services being rendered.

Sales representative: _____		Employer group: _____	
Employee/policy holder name: _____		Employee SS#: ____ - ____ - ____	
Member Information			
Member last name	First name	MI	Date of birth:
Street address	City	State	ZIP code:
Work phone #:	Home phone #:	Today's date:	Social Security #:
Relationship to employee: Spouse – Child - Other	AvMed effective date:	Primary care physician:	Physician phone #:
I. Ongoing medical treatment:			
Current active chemotherapy/radiation <input type="checkbox"/> Previous chemotherapy/radiation/dialysis <input type="checkbox"/> Transplant <input type="checkbox"/> Dialysis <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Open wound <input type="checkbox"/> Other: <input type="checkbox"/> (Please describe) _____			
II. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No High-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Due Date:	Obstetrician:	Physician Phone #:	Hospital you plan to deliver at:
Any complications during your pregnancy? If yes, please specify. <input type="checkbox"/> Yes (examples: high blood pressure, thyroid problems, diabetes) <input type="checkbox"/> No			
III. Prescription Medications: Please complete page 2			
If you are on insulin, do you use more than 3 vials (30ml) for a total of all doses per month? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have an Accucheck monitor? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use more than 50 test strips/month? <input type="checkbox"/> Yes <input type="checkbox"/> No			
IV. Current medical services (So we may assist the transition to your new group coverage.)			
Home Care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of agency: _____ Phone # _____ For what reason? (therapy, nursing, IV, wound care, etc) _____ Are you currently being treated at any wound care center or hyperbaric oxygen center? <input type="checkbox"/> Yes <input type="checkbox"/> No Current durable medical equipment: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type: CPAP <input type="checkbox"/> Oxygen <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Other <input type="checkbox"/> Please list: _____ Name of vendor: _____ Phone # _____			

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider to release for review my or my enrolled dependent children's (under age 18) medical records to AvMed Health Plans. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children for treatment, payment and health care operations.

Member Signature

Date

If AvMed's Nurse On Call has not contacted you within 14 days of submission of form, please call 1-888-866-5432.

Si usted prefiere recibir esta información en español, por favor llame al Departamento de Servicios a los Afiliados al número impreso en su tarjeta de identificación. Un representante bilingüe le ayudará.

TRANSITION OF MEDICATIONS

This section is to assist you with the transition of medications you have been taking in the 90-days prior to your effective date with AvMed. Some medications may be subject to AvMed's Progressive Medication Program and/or need a Prior Authorization initiated.

Today's Date: _____

Member Name: _____ **Date of Birth:** _____ **SSN or Mbr. ID#** _____

Directions: Please circle all prescription medications you are currently taking.

(*Note: This is **not** an all-inclusive list; please refer to the AvMed Preferred Medication list at www.AvMed.org for more information.*)

Progressive Medication Program List					
Progressive Medication Program (PMP): These programs encourage the first-line use of generics for members new to therapy or are switching therapies. AvMed will verify with your pharmacy that you have been on this medication and will then place an authorization in the system to allow you to continue to get that medication. Please note that if you switch brands or stop refilling your medication for a significant amount of time the PMP process will be required.					
Aciphex	Actonel	Atacand/HCT	Avalide	Avapro	Benicar/HCT
Boniva	Byetta	Caduet	Cozaar	Crestor	Diovan//HCT
Exforge	Fosamax D	Hyzaar	Inspira	Kapidex	Lescol XL
Lipitor	Micardis//HCT	Nexium	Pantoprazole	Prevacid	Restasis
Symlin//Pen	Teveten/HCT	Vancocin	Vytorin	Zegerid	
Medications That Require Prior Authorization					
Prior Authorization (PA) Required: This program is designed to require close monitoring of medications with potentially serious adverse effects, prevent medication misuse/abuse, and ensure the appropriate utilization of high cost agents. The PA program requires approval before the medication is covered by AvMed. We will initiate this process with your doctor on your behalf; therefore it is crucial that you provide us with your physician information.					
Actiq	Adderall/XR	Androderm	Androgel	Aranesp	Caphosol
Celebrex	Cimzia	Concerta	Crinone	Daytrana	Desoxyn
Dexedrine	Enbrel	Fentora	Focalin XR	Forteo	Fragmin
Hepsera	Humira	Imitrex Injs	Intron-A	IVIG	Leukine
Lovenox	Lupron	Marinol	Neumega	Neupogen	Omnitrope
Orencia	Oxandrin	Pegasys	Peg-Intron	Procrit	Promacta
Provigil	Remicade	Revatio	Ribavirin	Ritalin LA	Rituxan
Sandostatin	Selzentry	Serostim	Sporanox	Synagis	Tobi
Topamax	Tysabri	Uloric	Vyvanse	Xyrem	Xyzal
Xolair	Zyvox				
Write in any medication you are taking that is not listed above:					
Additional Information					
Pharmacy name and phone no.:					
Physician name and phone no.:					
Date of your last fill:					

Si usted prefiere recibir esta información en español, por favor llame al Departamento de Servicios a los Afiliados al número impreso en su tarjeta de identificación. Un representante bilingüe le ayudará.