Braven HEALTH Medical Transition of Care Benefit Request

Transition of Care, also referred to as treatment in progress, is a benefit that allows new subscribers and covered dependents to receive medical care by non-participating providers at their in-network level of benefits for treatment of an acute injury or illness. Transition of Care is short term and not intended to replace the regular provisions of the subscriber's Braven Health℠ insurance plan.

Examples of conditions that may meet Transition of Care guidelines

- Women who are pregnant and have had their first prenatal visit prior to the effective date of coverage
- Acute fracture victims
- Heart attack victims under acute care
- Cancer patients currently undergoing approved chemotherapy or radiotherapy treatment protocols
- Diagnosed terminal illness where life expectancy is less than 60 days
- Members hospitalization at the time of eligibility
- Surgery scheduled in the month prior to coverage effective date

Examples of conditions that may NOT meet Transition of Care guidelines

- Routine examinations, vaccinations and health assessments
- Stable but chronic conditions, (e.g., diabetes, hypertension, allergies, arthritis)
- Minor illnesses, (e.g., colds, sore throats, ear infections, bronchitis, strains, sprains)
- Long term management of cancer, dialysis, transplants, etc.

Transition Benefit Enrollment Process

All requests for transition care must be submitted in writing. The form on the following page must be completed and signed by you and your treating doctor. A separate form must be completed for each condition/doctor.
You may submit completed and signed forms, along with all supporting documentation, to us by email to HBCBSNJTransitionalBenefitsCoordinator_@HorizonBlue.com or by mail to

Braven Health Transitional Benefits Coordinator, PP- 12T
PO Box 420
Newark, NJ 07101-0420

Transition Review Process

1. Upon receipt of a completed and signed *Medical Transition of Care Request Form*, the Medical Department will review and evaluate the information.

2. Based upon this initial information, the subscriber will be informed, in writing, of the decision in one of three ways:
   a. Request for transition care approved for a specific period of time or a specific number of visits.
   b. Request for transition care denied.
   c. Request for additional information needed before a final decision can be made.

Eligible care rendered by non-participating providers after the transition period has expired will be paid at the out-of-network benefit level.

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Braven HEALTH

Medical Transition of Care Benefit Request

RESET

This form must be completed and signed by you and your treating doctor. Please complete a separate form for each treatment plan and/or doctor. You may submit completed and signed forms, along with all supporting documentation, to us by email to HBCBSNJTransitionalBenefitsCoordinator_@HorizonBlue.com or by mail to:

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Newark, NJ 07101-0420

To be Completed by the Subscriber/Patient

Subscriber Name ______________________________ DOB: ____________________

Address ____

Home Phone # ________________________ Work Phone # ______________________

Braven Health Member ID # ________________ Braven Health Group # _______________

Effective Date of Coverage __________________

Patient Name (if different than subscriber) ________________ DOB ________________

Address (if different than subscriber's) ______________________________________

Relationship to Subscriber __________________

Prior Insurance Carrier Name________________Policy/ID # ______________________

Did the prior carrier authorize treatment for the patient's condition/illness/injury? ☐Yes ☐No

Authorization # ____________________ Authorized Dates of Treatment ________________

Please provide a copy of the Authorization Approval or Determination Letter from the Prior Insurance Carrier.

Patient/Guardian Signature ____________________________ Date ___________________

By signing here, I hereby authorize the doctor noted to provide Braven Health or an affiliated Horizon BCBSNJ company with any and all information including medical records relating to the above diagnosis and treatment plan for Braven Health use in evaluating my request for Transition Care Benefits. This authorization is valid six months from the date signed above.

To be Completed by the Treating Doctor

Name ______________________________ NPI ______________________________

Practice Name ________________________ Practice NPI/TIN ____________________

Address ____

Phone ___________________FAX ___________________ Email __________________

ICD-10 Diagnosis Codes and Description of condition/illness/injury __________________

Date condition/illness/injury was diagnosed ___________________________________

Length of time patient was treated for this condition/illness/injury ____________________

Please provide a copy of the pertinent Medical Record information for your treatment of this patient.

Doctor's Signature ____________________________ Date ___________________

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