Mass General Brigham Health Plan

New Member Transition of Care Form

We're here to help! Our Customer Service Professionals will work with you and your providers so you can access medically necessary services, behavioral health services, and prescriptions. For example: medication infusions or scheduled surgery.

To be eligible for consideration, you or your dependent must:

- Be receiving ongoing care for specific health conditions* (See section 1 for typical medical conditions)
- Be receiving care that started prior to enrollment with Mass General Brigham Health Plan

Member information:

First name (Member receiving care) _____ Last name _____

Phone _____ Email address _____

Member ID number (if received) _____ Name of employer _____

Contact preferences:

1. What's the best way to reach you during business hours? ☐ Email ☐ Telephone
2. Do you give us permission to leave a message? ☐ Yes ☐ No

SECTION 1: Medical services

To request Transition of Care support for medical services, please select one or more of the following conditions:

- ☐ Pregnancy
- ☐ Sick newborn requiring intensive care
- ☐ Rare medical condition *(please specify details below)*
- ☐ Recent heart attack
- ☐ Specialty referral
- ☐ Scheduled or approved outpatient surgery
- ☐ Specialty pharmacy/home infusion
- ☐ Enrollment in a care management/ disease management program
- ☐ Cancer: newly diagnosed/ongoing cancer treatment

_____

_____

*Examples of chronic medical conditions that typically are not eligible for Transition of Care program (unless the condition is not stable OR the member receives IV medication infusions for a chronic condition) include arthritis, asthma, allergies, diabetes, hypertension, and COPD/emphysema.

Please provide full Provider contact information for conditions and treatment indicated above, next scheduled office visit(s), procedure or scheduled follow up appointment dates.

1. What is the name of the provider(s) you or your dependent receive care from?

Provider name _____ Phone _____ Provider address _____

Provider name _____ Phone _____ Provider address _____

Provider name _____ Phone _____ Provider address _____

2. When was the last time you or your dependent saw this provider(s) for the conditions noted?

_____

3. When is the next office visit, scheduled procedure, or follow up appointment with this provider(s)?

_____

4. Please complete the section below with any other relevant information that may help us better understand and support you with coordinating the medical care that you need.

SECTION 2: Prescription (RX) services

To request Transition of Care support for prescription services, please specify the medications that you or your dependent take and the frequency with which they are taken:

Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date
Medication name	Dosing/frequency	Last fill date

SECTION 3: Behavioral health services

To request Transition of Care support for outpatient behavioral health services with a provider that does not participate within our behavioral health provider network, please list your provider(s) below:

Provider name	Phone	Provider address
Provider name	Phone	Provider address
Provider name	Phone	Provider address

1. Do you receive care with this provider(s) in-person or virtually via Telehealth? ☐ In-Person ☐ Telehealth
2. How often do you see this provider(s) for care? ☐ Weekly ☐ Monthly ☐ Other

Member signature (Parent or legal guardian for members under age 18) Date

Return completed form by email, mail, or fax. A Customer Service Professional will get back to you to help you make a smooth transition. If you have questions, call Customer Service at **866-643-8392** *(Option 1)*.

Email: HealthPlanCustomerService-Members@mgb.org

Fax: 617-586-1799

Mail: Mass General Brigham Health Plan
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