



Transition Coverage Request

Personal & Confidential

This form represents a formal request for Aetna to cover continuing care from a **Non-Participating** Treating Physician or coverage for non-covered, rented Durable Medical Equipment (DME) for a specified period of time. You will receive a coverage determination by mail. For HMO and Elect Choice (EC) members, if the coverage is not approved, care by the non-participating provider after the plan's effective date will not be covered. For PPO (OC), HealthFund and POS (MC, QPOS, Choice POS II and USAccess) members, if the coverage requested is not approved, care by the non-participating provider after the plan's effective date either will not be covered or will be covered at the nonpreferred rate, if such a rate is available under the member's benefit plan.

For HMO products (HMO, QPOS®, Open Access™ HMO, Golden Medicare™, Medicaid) this form must be submitted to your Aetna Patient Management Unit at (non HMO products see Step 4 below):

States	Address/Fax
CT, MA, ME, NH, NY, RI, VT	Patient Management Unit, Attn: Non-Par Unit, 151 Farmington Avenue, Conveyor: MC1D, Hartford, CT 06156-7575 or Fax: 860-636-9129
NJ counties: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union, Warren	Aetna Northern NJ Non Par Unit, U29A, 930 Harvest Drive, PO Box 2244, Blue Bell, PA 19422 or Fax 215-775-5140
DC, DE, MD, PA, VA, WV, NJ counties: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem	Aetna Patient Management, Attn: Non-Par Unit, F247, 2201 Renaissance Blvd, P.O. Box 61517, King of Prussia, PA 19406-0916 or Fax: 484-322-6851
CO, IA, IL, IN, KS, KY, MI, MN, MO, MT, ND, NE, OH, SD, WI, WY	Patient Management Unit, Attn: Non-Par Unit, 100 North Riverside Plaza, 19 th Floor, Chicago, IL 60606 or Fax: 888-637-2712
AL, AR, FL, GA, LA, MS, NC, SC, TN	Patient Management Unit, Attn: Non-Par Unit, 11675 Great Oaks Way, Alpharetta, GA 30022 or Fax: 888-247-1017
AK, AZ, CA, HI, ID, NM, NV, OR, UT, WA	Patient Management Unit, Attn: Non-Par Unit, 2409 Camino Ramon, San Ramon, CA 94583 or Fax: 888-893-7709
OK, TX	Patient Management Unit, Attn: Non-Par Unit, 2777 Stemmons Freeway, Suite 300, Dallas, TX 75207 or Fax: 800-377-7078

Employee Instructions

1. Please complete Sections 1, 2, and 3.
2. Read the authorization, sign and date this part of the form. If the patient is age 17 or older, he or she must also sign and date this form.
3. Give the form to the patient's Non-Participating Treating Physician, who will complete Section 4 and send the completed form to Aetna.
4. **For OC, HealthFund, Choice POS II, MC or EC, please contact the Member Services telephone number on your ID card to obtain the correct Aetna Patient Management address for submitting this form.**

1. Employer Information	Employer's Name (Please print)	Plan Control Number	Plan Effective Date (Required)		
2. Employee/Patient Information	Employee's Name (Please print)	Social Security Number			
	Employee's Address (Please print)				
	Patient's Name (Please print)	Birthdate (MM/DD/YYYY)	Telephone Number		
	Name of Non-Participating Treating Physician or DME Provider (Please print)	Telephone Number			
3. Authorization	I am requesting coverage for continuing care or DME by the provider named above for a condition for which treatment began prior to the Plan effective date or prior to termination of the provider. If approved, I understand that the coverage for continuing care or equipment rental specified below will be covered for a limited period. Further, I authorize the Physician or DME Provider named above to provide medical information or records to the Plan as required to make a coverage determination.				
	Patient's Signature (Required if Patient is 17 or Older)	Date			
	Parent's Signature (Required if Patient is 16 or Younger)	Date			
4. Physician Information	The above named patient is a member in an Aetna Plan or will become a member in an Aetna Plan as of the Plan effective date. Although you are not or soon will not be a participating provider in the Plan network, the patient has requested that we cover care provided by you for a specified period of time because of a condition requiring an active course of treatment, or a pregnancy that began prior to the Plan effective date or effective date of termination. An active course of treatment is defined as a planned program of services rendered by a physician or DME provider starting on the date a physician first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment. So that we can evaluate your patient's request, please list the patient's diagnosis below. List all treatment for the condition and the dates rendered, attaching additional sheets if necessary. Also attach a brief statement of the patient's current condition and treatment plan, together with appropriate medical records. For pregnancies, please enter the patient's EDC. In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.				
	Diagnosis	Diagnosis Code	Treatment	CPT Code	Treatment Date(s)
	Name of Non-Participating Treating Physician or DME Provider (Please print)				Telephone Number
	Address of Non- Participating Treating Physician or DME Provider (Please print)				
	Signature of Non- Participating Treating Physician or DME Provider				Date

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. **California Residents:** For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.