

Fallon Health transition of care/continuity of care request form



- New Fallon Health enrollee (*Transition of Care applicant*)
- Existing Fallon Health customer whose health care professional is no longer part of Fallon network (*Continuity of Care applicant*)

Use a separate form for each condition. Photocopies are acceptable.
Attach additional information if needed.

Employer		Policy #	Employee date of enrollment in Fallon plan (mm/dd/yyyy)	
Employee name		Employee SSN or alternate ID		Work phone
Home address	street	city	state	ZIP
				Home/cell phone
Patient's name		Patient's SSN or alternate ID	Patient's birth date (mm/dd/yyyy)	
Relationship to employee				
<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Self				

- Are you pregnant and in the second or third trimester of pregnancy?
Due date _____(mm/dd/yyyy) Yes No
- If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes, etc. Yes No
- Are you currently receiving treatment for an acute condition or trauma? Yes No
- Are you scheduled for surgery or hospitalization after your effective date with Fallon? Yes No
- Are you involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? Yes No
- Are you receiving treatment as a result of a recent major surgery? Yes No
- Are you receiving dialysis treatment? Yes No
- Are you a candidate for organ transplant? Yes No
- Are you receiving mental health/substance abuse treatment? Yes No
- If you did not answer "Yes" to any of the above questions, please describe the condition for which you are requesting Transition of Care/Continuity of Care.

Please complete the health care professional information request on the next page.

Group practice name		
Health care professional name		Health care professional phone #
Health care professional specialty		
Health care professional address		
Hospital where health care professional practices		Hospital phone #
Hospital address		
Reason/diagnosis		
Date(s) of admission (mm/dd/yyyy)	Date of surgery (mm/dd/yyyy)	Type of surgery
Treatment being received and expected duration		

11. Are you expected to be in the hospital when coverage with Fallon begins or during the next 90 days? Yes No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care coverage. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care coverage, you need to complete a separate Transition of Care/Continuity of Care Form.
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I hereby authorize the above health care professional to give Fallon or any affiliated Fallon company any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care benefits under Fallon. I understand I am entitled to a copy of this authorization form.	
Signature of patient, parent or guardian	Date (mm/dd/yyyy)

Submit this request form to:
Fallon Health
 Attention: Katelyn Glennon
 10 Chestnut St., Worcester, MA 01608
 Fax: (508) 831-0912

For behavioral health related services, please contact Beacon Health Strategies by calling
 1-888-421-8861 (TDD/TTY: 1-866-727-9441)

