Member Health Survey and Transition of Care Application

UPMC Health Plan

Dear New UPMC Health Plan Member:

At UPMC Health Plan we believe there's nothing more important than your health and the health of your family. That's why we offer care and coverage of the highest quality and value to you every day. You have in-network access to world-class UPMC doctors and hospitals as well as excellent community hospitals and urgent care centers. And there are so many other incredible benefits to being a UPMC Health Plan member!

You have asked about **Transition of Care,** which is another important member benefit. This booklet tells you what you need to know about the Transition of Care process. It contains an application. Please complete it and send it back to us in the postage-paid envelope.

This booklet also contains a **Member Health Survey.** So that we can best serve you and your family, please complete this survey. It's about your current health and your health care needs. Your survey information is private and confidential. We will not share it with your employer or anyone outside UPMC Health Plan.

Both the Transition of Care and the Member Health Survey need to be completed and returned to UPMC Health Plan.

What is Transition of Care?

You may currently be receiving services from physicians or other health care providers or at hospitals or facilities that are not part of the UPMC Health Plan network. An approved Transition of Care request allows you, as a new member, to continue care for a medical condition, *under certain circumstances* and *for a specified period of time*, with a specialist or at a hospital or facility outside of the UPMC Health Plan network. Transition of Care is for members who are in active, ongoing treatment with a non-participating provider and whose treatment will continue *for a specific period of time* following their enrollment in UPMC Health Plan.

If you have a current, ongoing medical condition and would like to submit a Transition of Care request to continue treatment with your current provider, please complete the Transition of Care section of this form. You must send completed forms to the Health Plan within **30** days after your UPMC Health Plan coverage begins.

Additional information is available

If you have any questions about your benefits or services, call your Health Care Concierge team at **1-888-876-2756,** Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

We also encourage you to log in to *My*Health OnLine through UPMC Health Plan's website, **www.upmchealthplan.com,** which includes up-to-date information from the nation's leading health specialists. *My*Health OnLine provides members and their families with access to information on health topics such as nutrition, exercise, and medical conditions. If you would like to speak to a registered nurse about a specific health concern, call our *My*Health Advice Line 24 hours a day, seven days a week at 1-866-918-1591. Members may also submit email inquiries 24 hours a day/seven days a week using the Web Nurse Request system available on the UPMC Health Plan website. Responses to email inquiries will be within 24 hours of receipt of the original message.

Our online interactive tool, Emmi™, is your audio and visual "tour guide" for information you may want to review before you have certain surgeries or procedures. It can also help you understand the risks, benefits, and potential outcomes associated with certain chronic conditions. Find Emmi on *My*Health OnLine.

MEMBER HEALTH SURVEY — TO BE COMPLETED BY ALL NEW MEMBERS

Please complete a separate Member Health Survey for **each** person who is covered by this insurance plan.
Call **1-888-876-2756** for additional forms, or make copies of this form.

Read the entire survey. Clearly fill in the information requested in black ink. UPMC Health Plan may contact you with questions regarding specific answers you've provided.

Return completed forms to:
UPMC Health Plan
Medical Management — Ancillary Services
U. S. Steel Tower
600 Grant Street, 11th Floor
Pittsburgh, PA 15219
Fax: 412-454-2057

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Required Information

Are you completing the Member Health Survey or Transition of Care request for someone else?
☐ Yes ☐ No
If yes, throughout the document, "you" refers to the individual whom you are completing this form on behalf of. In addition, provide your name, address, and relationship to the member.

Name: ______________________________
Address: ______________________________
City/State/ZIP: ______________________________
Phone Number: ____________________ Relationship to the member: ____________________

If you are the member's personal representative, indicate the date when the Personal Representative Designation Form (PRDF) was sent to UPMC Health Plan. **Date:** __________

Request a PRDF by calling 1-888-876-2756 or by visiting **www.upmchealthplan.com.** Select Commonly Used Forms and choose Personal Representative Designation Form.

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About the member Please share with us some basic information.	
Member name	
Member address	
Member email	
Member ID #	
Employer group (if applicable)	
Daytime phone number	
Evening phone number	
Date of birth	

Health issues

Are you currently being treated for any of the following conditions?

Condition	Response	Condition	Response
Asthma	☐ Yes ☐ No	Hyperlipidemia (high cholesterol)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	End-stage renal disease	☐ Yes ☐ No
Chronic obstructive pulmonary disease (COPD)	☐ Yes ☐ No	Low back pain	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Sickle cell anemia/hemophilia	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No	Non-healing wounds	☐ Yes ☐ No
Hypertension (high blood pressure)	☐ Yes ☐ No	Other (please specify):	☐ Yes ☐ No

Have you ever participated in a health management program to help control your symptoms and better manage your condition?
☐ Yes ☐ No

If you have one or more of the following conditions: asthma, diabetes, COPD, congestive heart failure, coronary artery disease, high blood pressure, or high cholesterol, we will contact you to talk about our Health Management programs. These programs can help you manage your health care and live healthier. If you would like more information, please call our Health Management Department at **1-866-778-6073,** and select the prompt for the program you are interested in for more information.

Member Health Survey

Are you interested in talking to a UPMC Health Plan health coach for help with the following? (Check the topics that you would like to discuss.)

☐ Weight management
☐ Smoking cessation
☐ Stress management
☐ Physical activity
☐ Nutrition

Are you currently under the care of a physician and receiving one of the following treatments? (Check all that apply.)

☐ Chemotherapy
☐ Radiation therapy
☐ Kidney dialysis

Are you currently receiving any medical services in your home, including using supplemental oxygen or renting durable medical equipment (such as a wheelchair or hospital bed)?

☐ Yes ☐ No

If yes, indicate the name and phone number of the provider and the type of services being provided.

Name of Provider	Telephone	Type of services

Are you currently receiving home health care services in your home, such as intermittent daily or weekly nursing visits, or home physical, occupational, or speech therapy sessions?

☐ Yes ☐ No

If yes, indicate the name and phone number of the provider/agency and the type of services being provided.

Agency	Type of services

Do you receive private duty nursing services (continuous skilled nursing services for four hours or more per day from a nursing agency) in your home?

☐ Yes ☐ No

If yes, indicate the name and phone number of the provider/agency and the type of services being provided.

Agency	Type of services

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Transition of Care Request

Only complete this section if you are requesting Transtion of Care for yourself or a covered dependent. Please complete a separate form for each covered dependent.

Completed requests must be sent to the Health Plan within **30** days after your UPMC Health Plan coverage begins. Complete this section carefully. Incomplete information will delay the Transition of Care review process.

Reason for requesting Transition of Care

I am requesting Transition of Care to continue treatment for the following illness(es), condition(s), or health care service(s). Be specific.

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Protected Health Information (PHI) Disclosure Consent Form

In order for us to evaluate your Transition of Care application, we need to obtain your medical history from your doctors. That information is called your PHI. This section of the form will allow us to do that. If you are completing and signing this form for a member who is a minor or a covered dependent who is legally incompetent, provide your name, address, and relationship to the member.

About the member whose records are being requested:	
Member name	Member ID#

Name: ____

Address: ____

City/state/ZIP: ____

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Phone number: ____

Relationship to the member: ____

I, ______________________, authorize the providers I've named on page 6 to disclose my PHI or my legal dependent's PHI to the Medical Management Department at UPMC Health Plan, my new health insurance carrier. I understand that UPMC Health Plan's Medical Management Department will review my PHI as part of the Transition of Care process.

Authorized health care providers

To review your request, we will need to ask the provider(s) whom you identify below to disclose Protected Health Information (PHI) from your medical records and/or charts. UPMC Health Plan respects your privacy and keeps your records properly protected as directed by HIPAA (Health Insurance Portability and Accountability Act) regulations.

List the providers from whom we may obtain your PHI.			
Provider name:			
Provider address:			
City, state, ZIP:			
Phone number:			
Fax number:			

Check each box to indicate that you have read and that you understand the content.

☐ **Purpose of disclosure**
The purpose of this request and consent for disclosure is to allow UPMC Health Plan to receive all pertinent PHI needed to review and make a decision concerning this request for Transition of Care.

☐ **Expiration of consent**
This consent to disclose PHI in this form expires 60 days from the date of my signature below.

☐ **Need for renewal of consent**
If I do not revoke this consent, I understand that it will expire on the expiration date indicated above. If I wish to extend the consent, I must renew the consent by completing a new consent form.

☐ **Right to revocation**
I understand that I have the right to revoke this consent at any time. I understand that in order to revoke this consent, I must do so in writing and submit my written revocation to the UPMC Health Plan Member Services Department and to the health care provider(s) indicated on this form. I understand that any revocation will not apply to information that has already been released in reliance on this consent.

☐ **Lack of conditions**
I understand that I need not sign this consent form in order to ensure receipt of health care treatment, payment, enrollment in my health plan, or eligibility for health benefits by UPMC Health Plan/UPMC Health Network.

☐ **Right to retain a copy of this consent**
I am not making a copy of this consent form for my own records, and I wish to receive a copy from UPMC Health Plan/UPMC Health Network. I understand that I have the right to retain or receive a copy of this consent.

Signature: ______________________________ Date: ____________

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If we have questions about your Transition of Care request, we will call you. If you have questions while completing this form, call our Health Care Concierge team at **1-888-876-2756.** TTY users should call **1-800-361-2629.** Representatives are available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m.

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UPMC HEALTH PLAN

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

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