Allegiance®
Care Management

Transition of Care

EFFECTIVELY COORDINATE AND MANAGE YOUR MEDICAL NEEDS

Transition of care coverage allows you to continue to receive services for specified medical conditions for a defined period of time with health care professionals who are not in-network until the safe transfer of care to a participating doctor or facility can be arranged. You must already be under treatment for the condition identified as eligible for transition of care. Allegiance customer service can assist you in the process for determining if your condition is eligible.

Examples of acute medical conditions that may qualify for Transition of Care.

- ✓ Pregnancy in the second or third trimester
- ✓ Transplant candidates
- ✓ Newly diagnosed or relapsed cancer
- ✓ Acute conditions in active treatment such as heart attacks, strokes or unstable chronic conditions
- ✓ Recent major surgeries still in the follow up period
- ✓ Trauma
- ✓ Hospital confinement on the plan effective date

If you have questions about Transition of Care or would like to notify Allegiance about your transition of care condition.

Please contact Allegiance Customer Service at 1-855-999-6808

TRANSITION OF CARE

TRANSITION OF CARE DETAILS

Employer Name: Allen ISD

Employee Last Name	First Name, MI	Gender	SSN	Date of Birth (mm/dd/yyyy)

Home Address Street	City	State	Zip	Phone #

Height	Weight

Medical Coverage Selected: ☐ SINGLE ☐ SINGLE+SPOUSE ☐ SINGLE+CHILD(REN) ☐ FAMILY

COVERED DEPENDENT NAME	GENDER	DATE OF BIRTH	CURRENTLY RESIDING WITH YOU? (Y/N)	HAS MEDICAL INFORMATION BEEN PROVIDED BELOW?

Does Any Family Member have other medical insurance or Medicare? ☐ YES ☐ NO

If yes, who has other coverage and what is the Insurance Company Name? _____

MEDICAL HISTORY INFORMATION: TO BE COMPLETED BY APPLICANT

Have you, or any other covered person listed above received consultation or treatment of any of the following conditions in the past 2 years?

YES	NO		YES	NO		YES	NO	
☐	☐	Cancer/Neoplasm/Lymphoma	☐	☐	Leukemia	☐	☐	Lung Disease/Disorder
☐	☐	Arthritis	☐	☐	Connective Tissue Disorders	☐	☐	Multiple Sclerosis
☐	☐	Diabetes	☐	☐	Heart or Blood Disorder	☐	☐	Myasthenia Gravis
☐	☐	CVA/Stroke	☐	☐	Back/Joint Disorder	☐	☐	Neurological Disorder
☐	☐	Organ or Bone Marrow Transplant	☐	☐	Cerebral Palsy/Cystic Fibrosis	☐	☐	Any Pending Surgery or Hospitalization
☐	☐	Hypertension	☐	☐	Hyper or Hypothyroid	☐	☐	Or Condition > $10k in Claims
☐	☐	Congenital Disorder	☐	☐	Pregnancy Complications	☐	☐	Liver Disorders
☐	☐	Sickle Cell	☐	☐	Stomach/Intestinal Disorders	☐	☐	Renal Disorders
☐	☐	Injuries	☐	☐	Prescriptions > $2k Per Script	☐	☐	Chronic Psychiatric Disorders

Explain all Conditions Checked above in the table below.

PATIENT NAME	CURRENT DIAGNOSIS	DATE DIAGNOSED (MO/YR)	TYPE OF ONGOING CARE	LIST PERCRIPTION MEDICATIONS INCLUDING FREQUENCY AND DOSAGE

Authorization to release records:

I certify that the information contained in this transition of care form is true accurate to the best of my knowledge. This information is not being utilized to determine if you or any dependents are eligible to enroll in coverage. This information is solely being used to assist in the identification of members who might need assistance in the transition to the new insurance coverage.

Employee Signature Date