OhioHealthy

Transition of Care/Continuity of Care Referral Form

Thank you for choosing OhioHealthy for your health coverage! By giving us information about your health conditions and medications, we will be able to aid in your continuity of care and ensure a smooth transition to your new health plan. The assessment will take approximately five minutes to complete.

Completion of the form will help to prevent interruption of ongoing treatment and ensure the continuation of care and/or other approved services for a limited period of time once enrolled. You have 30 days from the first day you are eligible for benefits to complete and submit this form and you have 90 days to transition care to an in-network provider.

Completed forms can be emailed to caremanagement@ohiohealthyplans.com

i. **Required** Please provide your FULL government name and date of birth:

_____ _____ _____ _____

First Name *Middle Initial* *Last Name* *Date of Birth*

ii. **Required** Please provide names and dates of birth of all individuals being added to the plan:

First Name	Last Name	Date of Birth

iii. Please provide the best phone number, email address and mailing address to reach you, in case one of our Case Managers needs to follow-up with you.

Phone Number	
Email Address	
Mailing Address	

OhioHealthy

Transition of Care/Continuity of Care Referral Form

iv. **Required** Please provide the name of the primary care physician and specialists of each person covered under the health plan:

Covered Person	Primary Care Physician	Physician's Office

Appointments	No	Yes	Name of Covered Person(s)
Do you or anyone covered under your health plan have an upcoming appointment with any of your healthcare providers?	○	○	
Medical Equipment	**No**	**Yes**	**Name of Covered Person(s)**
Do you or anyone covered under your health plan use medical equipment for mobility and/or for use in day-to-day tasks?	○	○	
Medical Equipment (cont'd)	**No**	**Yes**	**Select the type of medical equipment needed:**
A) Do you or anyone covered under the health plan anticipate needing to receive any medical equipment within 30 days of new enrollment?	○	○	○ Oxygen ○ CPAP ○ Diabetes Supplies ○ Other
B) If you answered YES for part A, please list the names of covered persons who need the equipment	**Name of Covered Person:** _____ needs Oxygen/CPAP/Diabetes supplies **Name of Covered Person:** _____ needs Oxygen/CPAP/Diabetes supplies **Name of Covered Person:** _____ needs Oxygen/CPAP/Diabetes supplies **Name of Covered Person:** _____ needs Oxygen/CPAP/Diabetes supplies		

OhioHealthy

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v. **Required** Have you or anyone covered under the health plan ever been diagnosed with any of the following conditions?

Condition	No	Yes	If yes, name of person(s) diagnosed with condition
Asthma	○	○	
Heart Disease (Coronary Artery Disease, Angina, Heart Attack, A Fib)	○	○	
Chronic Obstructive Pulmonary Disease (COPD)	○	○	
Emphysema or Chronic Bronchitis	○	○	
Heart Failure (CHF)	○	○	
High Blood Pressure or Hypertension	○	○	
End Stage Renal Disease	○	○	
High Cholesterol	○	○	
Diabetes	○	○	
Stroke	○	○	
Arthritis	○	○	
Depression, Anxiety, or other Behavioral Health diagnoses	○	○	
Osteoporosis	○	○	
Cancer	○	○	
Alzheimer's or Dementia	○	○	

OhioHealthy

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vi. Do you or anyone covered under the health plan receive injected or infused medications administered by a healthcare provider?

Injected or Infused Medications	No	Yes	Select the place(s) where you receive the injection or infusion:
A) Do you or anyone covered under the health plan receive medications administered by a healthcare provider?	◯	◯	◯ Home Infusion ◯ Doctor's Office ◯ Infusion Center or Hospital
B) If you answered YES for part A, please list the names of covered persons, injected or infused medication, and provider. If you don't know the medication name, list the reason you take it and the provider.	**Name of Covered Person:** _____ Name of Medication: _____ Provider: _____ **Name of Covered Person:** _____ Name of Medication: _____ Provider: _____ **Name of Covered Person:** _____ Name of Medication: _____ Provider: _____		

vii. Are you or anyone covered under the health plan currently seeing a behavioral health provider?

Behavioral Health Provider	No	Yes	Name of Covered Person(s)
	◯	◯	
	◯	◯	

viii. Describe your general overall health and the health of anyone else covered under the plan:
(check only one per person)

Name of Covered Person(s)	Excellent	Good	Fair	Poor
	◯	◯	◯	◯
	◯	◯	◯	◯
	◯	◯	◯	◯
	◯	◯	◯	◯

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****Required** Authorization**

As a new OhioHealthy enrollee, I understand that OhioHealthy would like to collect some limited information about my health conditions and medications prior to the start of my new health plan coverage. I authorize OhioHealthy to share the information collected about my health or the health of my dependents with Care Management teams, my assigned OhioHealthy Plan physician, and OhioHealthy's pharmacy team to assist with continuity of care under my new OhioHealthy plan. I understand that my health information will be entered into a secured medical record. Any information received by OhioHealthy is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that I or my authorized legal representative may receive a copy of this Authorization upon request and I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that this Authorization is valid for three (3) months from the date shown.

Information disclosed from records is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure if expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

_____

Signature of Applicant or print and sign name of Legal Representative *(mm/dd/yyyy)*

Thank you for completing the Transition of Care/Continuity of Care Referral form. If you would like to talk to someone in Care Management about your care, e-mail caremanagement@ohiohealthyplans.com or call 614-485-7941.

3430 OhioHealth Parkway
Columbus, OH 43202