Transition of Care Request Form

Complete this form if you are undergoing a complex medical treatment in the first 30 days after your new plan's effective date. Imagine360 will use the information to help provide a smooth transition to the new plan and bring together the right resources to meet your needs.

First, complete Sections A, B, C and the attached Medical Release Form. Then, send to toc@imagine360.com.

Section A: Complex Medical Treatment

Please indicate which of the below are applicable:

- ☐ Inpatient admission or surgery within 30 days after your effective date
- ☐ Outpatient surgery or procedure within 30 days after your effective date
- ☐ Infusion treatment (**NOT** self-administered)
- ☐ Transplant evaluation or on transplant list
- ☐ Other complex treatment within 30 days after your effective date
- ☐ Currently pregnant
- ☐ Dialysis treatment
- ☐ Radiation or chemotherapy
- ☐ Clinical trial

Please list your current medications: _____

Section B: Member Information

Employer	Group #	Employee Date of Enrollment (mm/dd/yyyy)	
Employee Name		Employee ID	
Home Address	City, State	Zip	
Patient Name	Patient SSN	Patient DOB (mm/dd/yyyy)	Relationship to Employee
Patient Phone	Patient Email		Best Time to Call

Section C: Providers Treating Your Complex Medical Condition(s)

Provider Name	Next Date of Service	Please select: ☐ Office Visit ☐ Procedure
Provider Address	Provider Phone #	
Reason/Diagnosis	Date of Diagnosis	

Provider Name	Next Date of Service	Please select: ☐ Office Visit ☐ Procedure
Provider Address	Provider Phone #	
Reason/Diagnosis	Date of Diagnosis	

Provider Name	Next Date of Service	Please select: ☐ Office Visit ☐ Procedure
Provider Address	Provider Phone #	
Reason/Diagnosis	Date of Diagnosis	

Facility Name	Date(s) of Admission/Surgery
Facility Address	Facility Phone #
Reason/Diagnosis	

Medical Release Form

This form allows your health plan's medical management team access to information about your medical history to effectively assist you in your coordination of care. After completing this form, send it and the completed Transition of Care Request Form to toc@imagine360.com.

Employer	Policy #	Date (mm/dd/yyyy)	
Employee Name		Employee ID	
Home Address	City, State		Zip
Patient Name	Patient SSN	Patient DOB (mm/dd/yyyy)	Relationship to Employee
Patient Phone	Patient Email		Best Time to Call
Emergency Contact Name	Emergency Contact Phone Number		Relationship to Patient

Medical Release

I hereby give my authorization for the release both verbally and in writing, of my medical records, to include treatment diagnoses, diagnostic records, laboratory results, and other information in my health record to the health plan's medical management team. I understand that the health plan's medical management team will use these records to assess program needs as it relates to my health and that they may send these records to physicians or other healthcare providers for review as it relates to the notification or case management process.

By signing this release, I consent to enrollment in the medical management program.

Signature of Patient/Guardian: _____Date: _____

This release effective for one year following the date of my signature and applies to all current treating physicians and specialists (medical and/or mental) and family members as listed: _____

With respect to the HIPAA Privacy Rule, a permissible use or disclosure of Protected Health Information is for Treatment, Payment, or Healthcare Operations per section 164.502(a)(1)(ii). This request is being made by the health plan and its Business Associate for determining eligibility and coverage under the plan, reviewing heath care services for medical necessity, coverage, justification of charges, and the like; and utilization review activities which are defined as Payment per section 164.501 of the Privacy Rule.