Transition Coverage Request

Personal & Confidential

This form is a formal request for Aetna to cover continuing care from an out of network doctor or from certain other healthcare professionals (see related Transition Coverage Questions and Answers) from whom you have been receiving treatment. You will receive a coverage determination by mail. If the coverage is not approved, care by the non-participating provider after the plan's effective date either will not be covered or will be covered at the non-preferred rate if such a rate is available under the member's benefit plan. Please complete the following sections:

1. Section 1 (Employer Information)
2. Section 2 (Subscriber/Member Information)
3. Section 3 (Authorization) Read the authorization, sign and date the form (if patient is age 17 or older, he or she must also sign and date this form).
4. Give the form to the member's out of network provider to complete Section 4 (Physician Information).

Fax the completed form to Aetna for review.

Medical Requests (fax) 800-228-1318 or Behavioral Health/Substance Abuse Requests (fax) 215-775-4859

1. Employer Information	Employer's Name (Please print)	Plan Control Number	Plan Effective Date (**Required**)

2. Subscriber/Member Information			
	Subscriber's Name (Please print)		Subscriber's Social Security Number
	Subscriber's Address (Please print)		
	Member's Name (Please print)	Birthdate (MM/DD/YYYY)	Telephone Number

3. Authorization

I am requesting authorization for coverage of continuing care from the out of network healthcare provider named below for treatment which was initiated prior to my effective date with Aetna, or prior to the termination of the provider from the Aetna network. If approved, I understand that the authorization for services specified below will be covered for a limited period of time. In addition, I authorize the health care provider to send medical information and/or records requested by Aetna that are needed to make a coverage determination.

Patient's Signature (**Required** if Patient is 17 or Older)	Date
Parent's Signature (**Required** if Patient is 16 or Younger)	Date

4. Physician Information

Name of Out of Network Treating Physician or other healthcare professional (Please print)	Telephone Number
Address of Out of Network Treating Physician or other healthcare professional (Please print)	
Signature of Out of Network Treating Physician or other healthcare professional	Date

Please provide all specific information to avoid delay in the processing of this request.

The above named patient is currently a member of Aetna or will become an Aetna member as of the effective date indicated above. Although you are not or soon will not be a participating provider in the Plan network, the member has requested that we cover care provided by you for a specific period of time because of a condition requiring an active course of treatment, or a pregnancy that began prior to the Plan effective date or effective date of termination. An active course of treatment is defined as: "A planned program of services rendered by a health care provider starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment". Please include a brief statement of the member's current condition and treatment plan. For pregnancies please indicate the estimated date of confinement (EDC). In the event this request is approved you agree that you will not seek payment from the member for any amount the member would not be responsible for if you were a participating provider.

California HMO Terminated Providers – Although you are not or soon will not be a participating provider the Plan network, the patient has requested that we cover care provided by you for the completion of covered services, in accordance with California Health & Safety Code 1373.96. By signing this form, you agree to be subject to the same contractual terms and conditions, including rates and method of payment, that were imposed prior to termination. In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.

California HMO Non-Participating Providers – Although you are not a participating provider in the Plan network, the patient has requested that we cover care provided by you for the completion of covered services, in accordance with California Health & Safety Code 1373.96. By signing this form, you agree to the same contractual terms and conditions, including rates and method of payment, similar to those used by the Plan for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area. In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.

California Traditional Plan (not HMO) Terminated Providers – Although you are not or soon will not be a participating provider in the network, the patient has requested that we cover care provided by you for the completion of covered services, in accordance with California Insurance Code 10133.56. By signing this form, you agree to the same contractual terms and conditions, including rates and method of payment, as when you were under contract. In the event this request is approved, you agree that you will not seek payment from the patient for any amounts the patient would not be responsible for if you were a participating provider.

Please list diagnosis, specific treatment and specific dates of treatment	Diagnosis (including ICD9 codes)	Treatment (include related codes)	Dates of Treatment (current and anticipated)
	1.	1.	1.
	2.	2.	2.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.