Appendix VI

Medical Management

- Continuation of Care form – Transitional Coverage Request Form
- Medical Coverage Determination Form
Request For Continuity Of Care
For Medical Benefits
Transitional Coverage Request Form

Subscriber’s Name: ___________________________________  Subscriber ID No.: ____________________________
Address: ___________________________________________  City: ____________________  State: __________  Zip: __________
Daytime Tel: ___________________________  Home Tel: ____________________
Policy Effective Date: ___________________________
Other Insurance:  □ Yes*  □ No
*If yes, Name of Insurance: ___________________________  Effective Date: ____________________

This request applies only to members that are currently in treatment for an unstable, severe or life-threatening condition that requires continuation of care with their current provider or for those who have entered their second trimester of pregnancy on or before their VNSNY CHOICE effective date. Please have your Provider complete the following:

Form Completed By: ___________________________  Title: ___________________________
Name of Treating Provider: ___________________________  Hospital/Affiliation: ___________________________
Primary Diagnosis: ___________________________
Complications: ___________________________
If pregnant, give estimated Due Date: ___________________________
Date started 2nd trimester: ___________________________  Date of Most Recent Visit: ___________________________
Frequency of Visits: ___________________________
Date of Most Recent Hospitalization (if applicable): ___________________________
Name of Hospital: ___________________________
For the latest Hospitalization please provide:
○ Primary Diagnosis  ○ Copy of discharge summary  ○ Copy of operative report  ○ Copy of pathology report

Current Therapy: ___________________________
Proposed Treatment Plan: ___________________________
Duration Treatment: ___________________________
I agree to accept VNSNY CHOICE reimbursement as payment in full. I also agree to comply with all of VNSNY CHOICE UM/QI policies and procedures.
Physician Signature: ___________________________  Date: ___________________________

I understand that requests for continuity of care transition benefits are approved at the sole discretion of VNSNY CHOICE and the term of any such transition period will terminate when VNSNY CHOICE determines that care can be safely transferred to a network participating provider. I further understand that once the transition period has expired or my request is denied, the benefit for out-of-network services as stated in my subscriber contract will apply. I understand that any claim by me may be denied and/or coverage cancelled without written notice if I have provided materially false information in my request. My signature below authorizes the provider indicated to release medical records to VNSNY CHOICE Utilization Management Department in order to review this request. I have reviewed the information supplied on this form and attest to its accuracy to the best of my knowledge.

Member’s Signature: ___________________________  Date: ___________________________

To expedite this process, please FAX form to: 1-866-791-2214 OR mail form to:
VNSNY CHOICE Medicare
Attn: UM Department
1250 Broadway
New York, NY 10001

For Office Use Only:
□ Approved  Date: ___________________________
□ Denied  Signature: ___________________________

Transitional Coverage Request Form 11/2010
# Medical Coverage Determination Form

**FAX AUTHORIZATION REQUEST FORM FOR COVERAGE DETERMINATIONS**

Please utilize this form as an alternative to calling in request(s) or services. This form should be faxed to VNSNY CHOICE Utilization Management Department at 1-866-791-2214. Should you have any questions please call 1-866-793-0222. Thank you for your cooperation.

### PATIENT & INSURANCE INFORMATION (PLEASE FILL-IN AVAILABLE)

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Patient Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID #</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Patient’s Home Telephone</td>
<td>Alternate Telephone</td>
</tr>
<tr>
<td>Other insurance</td>
<td>Effective Date</td>
</tr>
</tbody>
</table>

Is this service related to: □ Motor vehicle accident □ Worker’s Compensation □ Other

### AUTHORIZATION INFORMATION

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Service Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of onset of service/hospital admission</td>
<td>Requested length of stay/service</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ICD9 Code(s)</td>
</tr>
<tr>
<td>Procedure</td>
<td>CPT Code(s)</td>
</tr>
</tbody>
</table>

In order to expedite your request in a timely manner, please submit copies of all pertinent medical information.

### PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Ordering/Attending Physician Name</th>
<th>Tax ID</th>
<th>Provider’s area(s) of subspecialty or expertise.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City/State</td>
<td>Zip</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>Fax Number</td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Telephone Number</td>
<td>Tax ID Number</td>
</tr>
</tbody>
</table>

Submitted by

<table>
<thead>
<tr>
<th>Provider Signature</th>
</tr>
</thead>
</table>

### FOR INTERNAL USE ONLY

| Authorization Status: □ Approved Authorization #:________________________ |
|-----------------------|-----------------|
| LOS/# Visits: ____________________ Dates of Service:____________________ |

□ Denied □ Pended

Additional Information ___________________________ Medical Review ___________________________

**CONFIDENTIALITY NOTICE**: This fax transmission contains information to the sender, which may include proprietary information of VNSNY CHOICE. The information is intended only for the use of the individual identified above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this faxed information is strictly prohibited. If you have received this fax in error, please notify us by telephone immediately to arrange for return or destruction of the documents.

Service Request form 11/2010