Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

Transition of Care Form

Welcome to Florida Health Care Plans! It is the goal of the Transition of Care Team to assist you with transitioning into our network of providers, pharmacies & covered medications. Please complete the TRANSITION OF CARE FORM. You will be contacted if additional information is needed.

Please return to the Transition of Care Nurse Navigator by Adobe Sign, fax at 386-238-3271 or by mail to FHCP Case Management Department, Attn: Transition of Care, PO Box 9910, Daytona Beach, FL 32120. Questions can be directed to the Transition of Care line at 386-615-5017 or by email to TOC@fhcp.com. TTY: 1-800-955-8770. Hours of operation are Monday through Friday, 8:00 am to 5:00 pm. EST. We are happy to assist you in transitioning into your health coverage with Florida Health Care Plans.

Disclaimer – Standard Prior Authorization procedures & guidelines apply. Transition of Care is a service for new members transitioning into the FHCP network. Submitting this form does not guarantee continued care with out-of-network providers, pharmacies, medical suppliers, or coverage of non-formulary medications. You may be financially responsible for charges if you receive services outside of the FHCP network without an approved authorization. It is your responsibility to notify your providers of your insurance change.

Member Name: _____ Member #: _____

Plan Effective Date: _____ DOB: _____ Gender: _____

Address: _____

Preferred Phone #: _____

Alternative Phone #: _____

Email Address: _____

Today's Date: _____

Emergency Contact (Name, Relationship & Phone #):

Name	Relationship	Phone #

If you wish for your Protected Health Information (PHI) to be released to others, please complete, sign and return the Authorization to Release PHI form.

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association. FHCP Medicare is administered by Florida Health Care Plan, Inc.

Member Name: _____ MRN:_____

Current Medical Concerns: _____

PCP (Name, Phone #, City & State): _____

Last Visit: _____

SPECIALISTS

(Name, Specialty, Phone #, City & State, Hospital/Group Affiliation)-

Name	Specialty	Phone	City/State	Hospital/Group Affiliation

UPCOMING APPOINTMENTS or PROCEDURES

Please use the NOTES section on page 4 if additional space is needed -

Date	Provider	Procedure	Visit Type

RECENT VISITS TO EMERGENCY ROOM or URGENT CARE?

(Date, Name/Location of ER or UC, Reason for Visit) -

Date	Name/Location	Reason

In order for FHCP to request your medical records from an out-of-network provider, please complete, sign & return an Authorization to Release PHI Form.

Member Name: _____ MRN:_____

CURRENT MEDICATIONS

(Drug Name, Dose, Frequency, Prescribing Provider Name)

If you are submitting a Medication Transition Form, skip this section.

Please note if free samples or enrolled with patient assistance programs.

Drug name	Dose	Frequency	Prescribing Provider

Please list all **ALLERGIES** with **REACTION:** _____

CURRENT PHARMACIES USED

(Name, Location & Phone #, Samples, or Patient Assistance Program)

Pharmacy/Patient Assistance program/Samples from	Location	Phone

DURABLE MEDICAL EQUIPMENT & OTHER MEDICAL SUPPLIES

(Oxygen, CPAP, Insulin Pump, Ostomy supplies etc.).

Please include name of supplier & prescribing provider.

DME/Supplies	Company/Supplier	Contact number	Prescribing Provider

Are you in danger of running out of any medication, DME or medical supply in the near future or soon after your effective date with FHCP? ☐ YES ☐ NO

If YES, please list the name of the medication, medical equipment, or supply with the approximate date you will be without.

_____

_____

Member Name: _____ MRN:_____

ADDITIONAL INFORMATION: