GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care
The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization Provider (PPO Provider), Hospital, or other provider is terminated from the Anthem Blue Cross participating provider network.
- They are a new enrollee in an Anthem Blue Cross plan (except members with an Individual contract) and their treating provider is not part of the Anthem Blue Cross participating provider network.
- Continuity of care is at risk for reasons over which the member has no control. (Members who have elected to make changes in their coverage which cause them to be out-of-network are not eligible for this program).

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact Anthem Blue Cross Customer Care.

Completing the Continuity/Transition of Care Request Form
You may request Continuity/Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a newborn child between the ages of birth and 36 months. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the Customer Care Number on the back of your Anthem Blue Cross card or the Customer Care number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Or, fax this completed request form to 1-877-214-1781.
Continuity of Care/Transition of Care Request Form

To help ensure that your care is not disrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care. **For Medical Care:** If you are changing to a PPO or EPO and your current medical provider is in our network, or if you are changing to an HMO and will stay in your current PMG or IPA, you do not need to complete this form. If you are in a HMO and your provider is leaving the PMG/IPA, you do not need to complete this form, you need to contact your PMG/IPA and they will assist you with your transition to a contracting provider. **For Behavioral Health Care:** If you are changing plans and your provider is not in the Anthem network, please complete this form.

**Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation.** Please complete a separate form for each family member who needs to have care transitioned to another provider.

| Subscriber's Name: ____________________________ | Subscriber's Anthem Blue Cross ID #: ____________________________ |
| Subscriber’s Employer: __________________________ | Date Active with Anthem Blue Cross: ____________________________ |
| Patient’s Name: ____________________________ | Relationship to Subscriber: ____________________________ |
| Date of Birth: ____________________________ | Allergies: ____________________________ |
| Preferred Phone #: ____________________________ | Home Work Cell: ____________________________ | Secondary Phone#: ____________________________ | Home Work Cell: ____________________________ |
| Name of Terminating Insurance Plan: ____________________________ | Circle Type of Terminating Plan: HMO PPO EPO CDHP OTHER |
| New Anthem Blue Cross Plan: HMO PPO EPO CDHP OTHER | Are You a New Enrollee to Anthem Blue Cross: Yes No |
| Name of PMG/IPA with Terminating Plan: ____________________________ | Name of New Anthem Blue Cross PMG/IPA: ____________________________ |

For Network Disruption (PMG, IPA, PPO Provider, or Hospital has terminated from the Anthem Blue Cross Participating Provider Network) please provide the name of the terminating Hospital or Provider: ____________________________

Diagnosis (include pertinent history and physical findings): ____________________________

1. Do you have an upcoming appointment to see a specialist? Yes No

If yes, please provide the applicable information below.

<table>
<thead>
<tr>
<th>Specialist Type</th>
<th>Provider Name (last, first)</th>
<th>Provider Phone Number</th>
<th>Date of Office Visit</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood or Cancer Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Disease Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic Specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrician for pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due Date: Hospital for delivery:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Please be specific</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continuity of Care: Application New Enrollee and Application Network Disruptions consolidated herein. Last revised 07/12/10

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. © ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association. Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.
Continuity of Care/Transition of Care Request Form

2. Are you currently receiving any of the following services? Yes  No

If yes, please provide the applicable information below.

<table>
<thead>
<tr>
<th>Services</th>
<th>Facility or Company, Medical or Behavioral Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Laboratory</td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
</tr>
<tr>
<td>IV Medication/Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td></td>
</tr>
<tr>
<td>Home Therapy</td>
<td></td>
</tr>
<tr>
<td>Rehab Treatment</td>
<td></td>
</tr>
<tr>
<td>Organ or Stem Cell/Bone Marrow Transplant</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Medication Management for a Behavioral Health condition</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
</tbody>
</table>

3. Do you have any hospitalizations, surgeries or procedures scheduled? Yes  No

Date __________________ Type of Surgery/Procedure _______________________________

Name/Phone Number of Physician performing surgery/procedure _______________________________

Hospital/Facility ___________________________________________________________________

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? Yes  No

Reason ____________________________________________________________________________

Hospital _______________________________________________________________________________

Date(s) of Service _________________________________________________________________

5. Other Needs ___________________________________________________________________

I hereby authorize the above provider to give the Anthem Blue Cross Transition Assistance Department any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that I am entitled to a copy of this authorization form. I also authorize Anthem Blue Cross to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

__  Home    __  Cell    __  Work    ___ Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over: _____________________________________________________________________ Date: ____________

Signature of Parent or Guardian if Patient is under 18: _____________________________________________________________________ Date: ____________