

# TRANSITION OF CARE

Welcome to Group Health Cooperative of South Central Wisconsin (GHC-SCW). Regardless of the clinic you choose, we can assist you with your health care needs during this transition period. To facilitate this, please complete the form below for each person in your family covered by this policy. If you have any questions, please contact the Care Management Department at (608) 257-5294.

**Submit the completed form in one of three ways:**

1. Save form as a pdf and upload completed form to [www.ghcscw.com/for-members/transition-your-care](http://www.ghcscw.com/for-members/transition-your-care)
2. Please fax completed forms to **(608) 733-6316**.
3. Forms can also be sent in the mail to: **GHC-SCW Care Management, 1265 John Q Hammons Drive, Madison, WI 53717.**

\*For children 18 years and older, a release will be needed to discuss health information with parents.

<b>New Member Name:</b>	<b>Date of Birth:</b>
<b>Parent Name (if applicable):</b>	<b>Date of Birth:</b>
<b>Phone Number:</b>	<b>Best Time to Be Reached:</b>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any visits you had previously scheduled, which occur within 90 days of beginning coverage with GHC-SCW. Primary Care Provider and first time visits with a specialty provider are not eligible for transition of care coverage. Transition of Care services are not guaranteed and must be a covered benefit.

Appointment	Date	Specialty	Diagnosis	Specialist Name and Clinic

Do you use any durable medical equipment (ex. CPAP, infusion pumps, prosthetics)? Yes  No

Do you receive any specialty injectable medications or infusions? Yes  No

Please list the name, dose and prescribing provider of **ALL** prescriptions you currently use. Our pharmacy staff will review your list and contact you or work with your provider to address any potential coverage issues.

Medication	Dose	Prescribing Provider