Continuity of Care/Transition of Care Request Form Required Fields Checklist

Instructions:

- Required fields will not allow you to continue without a response
- The checklist below lists the required questions; please try to answer all of the questions, even if they are not required, because it will help with a decision for your request

Plan Information

- ☐ Plan type (Oscar or Cigna+Oscar)
- ☐ State

Member Information

- ☐ Name
- ☐ Date of Birth
- ☐ Member ID #

Requestor Information

- ☐ Is the person completing the form the member or authorized representative?
  - ☐ If authorized representative:
    - ☐ Name
    - ☐ Relationship to member
    - ☐ Permission to assist member?
    - ☐ Phone number

Requested Provider

- ☐ Are you a new member or has your provider left the network?
- ☐ Provider type/specialty
- ☐ Provider state
- ☐ Provider full name
- ☐ Phone #
- ☐ Fax #
- ☐ When was your last visit?

Facility or Vendor Information (If applicable)

- ☐ Facility/Agency/Vendor name
- ☐ Facility/Agency/Vendor Address
- ☐ Phone number (+ ext.)
- ☐ Fax number

Condition/Diagnosis Code

- ☐ ICD 10 Diagnosis OR description of condition
- ☐ Are you requesting concurrent (while receiving services) vs preservice (before receiving services)?
- ☐ Are you requesting specific dates of service?

Service Information

- ☐ Is this request for consultation/visits or specific services?
- ☐ (if visits is marked) # of visits requested
- ☐ (if specific services is marked) Inpatient or outpatient
- ☐ Service Type
- ☐ Place of Service
- ☐ Are you able to provide procedure codes?
    - ☐ If yes, list them and quantity

Service Timing and Dates

- ☐ Are you requesting specific dates?
    - ☐ If so, list them

Existing Case

- ☐ If this is a request to extend or renew a previous out-of-network approval, please indicate your reference number

Medical Records

- ☐ Upload medical records if possible

Out of Network Request Form Required Fields Checklist

Instructions:

- Required fields will not allow you to continue without a response
- The checklist below lists the required questions; please try to answer all of the questions, even if they are not required, because it will help with a decision for your request

Plan Information

- ☐ Plan type (Oscar or Cigna+Oscar)
- ☐ State

Member Information

- ☐ Name
- ☐ Date of Birth
- ☐ Member ID #

Requestor Information

- ☐ Is the person completing the form the member or authorized representative?
  - ☐ If authorized representative:
    - ☐ Name
    - ☐ Relationship to member
    - ☐ Permission to assist member?
    - ☐ Phone number

Requested Out-of-Network Provider

- ☐ Are you requesting out-of-network care with a specific provider?
  - ☐ If yes:
    - ☐ Name
    - ☐ Phone number
    - ☐ Fax number
    - ☐ Have you established care with this provider?
- ☐ Provider Type/Specialty
- ☐ Provider State

Referring Provider Information

- ☐ Are you being referred to receive out of network care by a provider other than the requested out-of-network provider?
  - ☐ If yes:
    - ☐ Who is the referring provider?
    - ☐ Provider full name

- [ ] Phone number (+ext)
- [ ] Fax number

Condition/Diagnosis Codes

- [ ] ICD 10 Diagnosis OR description of condition
- [ ] Are you currently experiencing any side effects related to this condition/diagnosis?
    - [ ] If yes
        - [ ] Please describe

Service Timing and Dates

- [ ] Are you requesting concurrent (while receiving services) vs preservice (before receiving services)?
- [ ] Are you requesting specific dates?
    - [ ] If so, list them

Facility or Vendor Information (If applicable)

- [ ] Facility/Agency/Vendor name
- [ ] Facility/Agency/Vendor Address
- [ ] Phone number (+ ext.)
- [ ] Fax number

Procedures

- [ ] Are you able to provide procedure codes?
    - [ ] If yes, list them and quantity

In-Network Providers

- [ ] Have you seen any in network provider(s) for this condition previously?
    - [ ] If yes, was the in network provider(s) able to treat you for this condition?
    - [ ] Please list all of the in network provider(s)/facilities that have been unable to treat you why they were unable to treat

Medical Records

- [ ] Oscar will require medical records to make a decision on your out-of-network authorization request. Who can we request medical records from?
- [ ] Provider full name
- [ ] Phone number (+ext)
- [ ] Fax number

Existing Case

- [ ] If this is a request to extend or renew a previous out-of-network approval, please indicate your reference number