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