Transition of Care Application

If you are actively undergoing treatment for a ***serious, life threatening medical condition, and your primary specialist is not covered in the Fallon Select network***, you may be eligible for a reduced rate to help you remain on your current Harvard Pilgrim, Tufts or Blue Cross Blue Shield health insurance plan.

This application must be fully completed and submitted to the Fallon Patient Advocate by June 1st.

If your application is denied, you may appeal the decision to the Health Insurance Subsidy Review Board by sending a request to Human Resources, Town Hall, 525 Washington Street, Wellesley, MA 02482. Please include a copy of the original application and any back-up information you feel is necessary for the Review Board to make an informed decision. You must file an appeal within 3 days of notification that your application has been denied.

Please remember, to qualify you must:

1. Be diagnosed with a serious, life threatening condition or one that could lead to a serious or permanent disability if left untreated.

2. Currently be undergoing active treatment which is defined as "treatment following an inpatient stay or outpatient procedure for recovery or rehabilitation for a serious disease. It may include continuing care for a serious disease that requires diagnostic tests or adjustment of medications or treatments that occur and are scheduled every six months or sooner. Continuing care that occurs at intervals greater than every six months would not qualify as active treatment. It may also include an inpatient procedure for a serious disease that was scheduled on or before July 1, 2018. Active treatment does not include preventive services or services to monitor a patient's condition after the patient completes treatment for a serious disease. It also does not include clinical trials, experimental treatments, off-label use for products or products not approved by the Food and Drug Administration in circumstances where these services would not otherwise be covered. Active treatment shall also include mothers who give birth after April 30, 2018 and before July 1, 2018 if the mother requires postpartum care and the mother's care provider(s) is not covered under the Fallon Select plan/network."

3. Your primary specialist is not covered under the Fallon Select network: Primary specialist (may include but not limited to): a primary medical specialist in the following fields or practice; cardiologist, endocrinologist, gastroenterologist, hematologist, oncologist, maternal fetal medicine, neonatologist, neurologist, nephrologist, orthopedist, urologist, medically necessary plastic surgeon, pediatric specialist.

4. Or be an employee/non-Medicare eligible retiree whose permanent address, as listed in the Town of Wellesley payroll system, is outside the Fallon service area of all of Massachusetts, except for the communities beyond the Cape Cod Canal. IN addition, the employee/non-Medicare eligible retiree must have utilized at least one provider who is a non-Fallon provider within the last year.

Approved subscribers will be eligible for a subsidy of up to $1,400 per plan year for an individual Benchmark plan or $3,800 per plan year for a family Benchmark plan and up to $700 per plan year for an individual High Deductible plan and up to $2,000 for a family High Deductible plan. This subsidy will be included in your monthly premium contribution.

Please make sure to submit the original application to the address listed on the last page of this application.

Fallon Health transition of care/continuity of care request form

☐ New Fallon Health enrollee *(Transition of Care applicant)*
☐ Existing Fallon Health customer whose health care professional is no longer part of Fallon network *(Continuity of Care applicant)*

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employer	Policy #	Employee date of enrollment in Fallon plan (mm/dd/yyyy)	
Employee name	Employee SSN or alternate ID	Work phone	
Home address street city state ZIP		Home/cell phone	
Patient's name	Patient's SSN or alternate ID	Patient's birth date (mm/dd/yyyy)	Relationship to employee ☐ Spouse ☐ Dependent ☐ Self

1. Are you pregnant and in the second or third trimester of pregnancy?
   Due date_____(mm/dd/yyyy) ☐ Yes ☐ No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes, etc. ☐ Yes ☐ No
3. Are you currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No
4. Are you scheduled for surgery or hospitalization after your effective date with Fallon? ☐ Yes ☐ No
5. Are you involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ☐ Yes ☐ No
6. Are you receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
7. Are you receiving dialysis treatment? ☐ Yes ☐ No
8. Are you a candidate for organ transplant? ☐ Yes ☐ No
9. Are you receiving mental health/substance abuse treatment? ☐ Yes ☐ No
10. If you did not answer "Yes" to any of the above questions, please describe the condition for which you are requesting Transition of Care/Continuity of Care.

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Please complete the health care professional information request on the next page.

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Group practice name		
Health care professional name		Health care professional phone #
Health care professional specialty		
Health care professional address		
Hospital where health care professional practices		Hospital phone #
Hospital address		
Reason/diagnosis		
Date(s) of admission (mm/dd/yyyy)	Date of surgery (mm/dd/yyyy)	Type of surgery
Treatment being received and expected duration		

11. Are you expected to be in the hospital when coverage with Fallon begins or during the next 90 days? ☐ Yes ☐ No
12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care coverage. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care coverage, you need to complete a separate Transition of Care/Continuity of Care Form.

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I hereby authorize the above health care professional to give Fallon or any affiliated Fallon company any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care benefits under Fallon. I understand I am entitled to a copy of this authorization form.	
Signature of patient, parent or guardian	Date (mm/dd/yyyy)

Submit this request form to:
Fallon Health
Attention: Katelyn Glennon
10 Chestnut St., Worcester, MA 01608
Fax: (508) 831-0912

For behavioral health related services, please contact Beacon Health Strategies by calling 1-888-421-8861 (TDD/TTY: 1-866-727-9441)

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Additional notes/comments: