TRANSITION OF CARE FORM

In order to facilitate continuity of care for scheduled surgeries or planned procedures, or **complex or chronic conditions** for which you or your dependents are undergoing regular treatment, please complete all the information on this form and mail or fax it to the Health Services Director, Coventry Health and Life Insurance, Inc., **Attn: Health Services Dept.** at 14955 Heathrow Parkway, Houston, TX 77032 or FAX # 888-399-1831**.**

GROUP EMPLOYER NAME

____

MEMBER NAME ______________________________
Last Name, First Name, Middle Initial

SOCIAL SECURITY NUMBER _______ - _______ - _______

MEMBER NUMBER (if known) ______________________________

DATE OF BIRTH ______________________________
MM/DD/YY

DEPENDENT NAME (if applicable) ______________________________
Last Name, First Name, Middle Initial

RELATIONSHIP/DATE OF BIRTH ______________________________
Spouse, Child, MM/DD/YY

ADDRESS

____
Street Name, Number, Apt. #

____
City, State, Zipcode

DAYTIME PHONE #: ____________________ **EVENING PHONE #:** ____________________

If you are currently being treated for a complex or chronic condition or have scheduled procedures, please complete all requested information on this form.

Complex or chronic condition being treated (please complete page 3 if you have one of the specific conditions listed):

____
Diagnosis

Nature and frequency of treatment: Briefly describe any therapies, treatments, regular appointments, scheduled procedures, prescription drugs, etc., that you are currently receiving or plan to receive and the frequency of such treatment (e.g. daily, weekly, monthly, etc.). Please include any hospitalizations, providing facility name and dates of admission and discharge.

____

____

____

TREATING PHYSICIAN

____ ________________________
Physician Name Specialty

____
Address 1

____
Address 2

____ ________________________
City, State, Zipcode Phone #

PRIMARY CARE PHYSICIAN selected with Coventry Health Care (if applicable)

____
Physician Name

____
Address 1

____
Address 2

____ ________________________
City, State, Zipcode Phone #

Other important information or comments about your condition:

____

____

____

ASTHMA: ☐ Y ☐ N Date diagnosed? ____________________
Use peak flow meter? ☐ Y ☐ N Use a spacer? ☐ Y ☐ N

Attending Physician Name & Phone #: ____
Please list treatment regimen including medications:

____
____
____

PREGNANCY: ☐ Y ☐ N Anticipated delivery date: __________________
Pregnancy history:

____
____

Obstetrician Name & Phone #: ____

DIABETES: ☐ Y ☐ N Diagnosis date: __________________
Do you use a glucometer to check blood sugars? ☐ Y ☐ N If yes, how often? ___________
Please list all medications:

____
____
____

Last blood hemoglobin A1C test: ______________________ Result: ___________________
Physician Name & Phone #: ____

CONGESTIVE HEART FAILURE: ☐ Y ☐ N Diagnosis date: _________________
Please list treatment regimen including medications:

____
____
____

Physician Name & Phone #: ____

RENAL FAILURE OR ON DIALYSIS: ☐ Y ☐ N Date dialysis started? ______________

Nephrologist Name & Phone #: ____
Dialysis Center Name & Phone #: ____
Type of Dialysis: ____
Medicare status: ____

Please complete the Transition of Care form:
1) Place in a sealed envelope and mail to Coventry Health and Life Insurance, Inc., **Attn: Health Services Dept.** at 14955 Heathrow Forest Parkway, Houston, TX 77032 or
2) Fax to Coventry's confidential Health Services number at 888-399-1831**.**