SUMMIT HEALTH

Transition of Care Request

Member transitioning on to new plan ☐

Continuity of Care Request

Provider terming from network ☐

Patient name	Date of birth (mm/dd/yyyy)	ID no.	Patient phone
Provider/Physician		**Contact Name**	**Provider/Physician phone**
Facility (if applicable)		**Contact Name**	**Facility phone**
Diagnosis	**CPT Codes/Service/Procedure(s)**		**If pregnant, due date**
Requested Date Span			

Please include a brief clinical summary of patient's condition and treatment plan below (to be completed by attending physician). If request is approved by previous carrier please provide CPT Code/Diagnosis Code/Provider/Facility/Date of service approved. Certain requests require clinical/chart notes for further review. Please attach clinical/chart notes if applicable

Provider Signature

Ready to submit? Fax request form and supporting clinical documentation to 503-243-5105, or secure email to transitionofcare@yoursummithealth.com

Questions? Contact Summit Health at 844-827-2355 or at MedicalMedicare@YourSummitHealth.com