Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Toll-Free: (855) 305-5060
TTY/TDD: (877) 652-1844
Translation Assistance: (800) 892-0675
Fax: (605) 328-6811
sanfordhealthplan.com

SANFORD HEALTH PLAN

North Dakota Medicaid Expansion Transition of Care Request Form

We know the importance of a relationship between a patient and their provider. Due to the January 1, 2018 network changes, please fill out this Transition of Care Request Form if:

- Your provider will no longer be in the Sanford Health Plan's network as of January 1, 2018 **and**
- You are affected by a specific health problem as listed below.

NOTE: Completing this form does not mean a service will be approved or paid for by Sanford Health Plan.

Follow the steps below to find out if you should complete this form or not.

STEP 1: Make sure that your health care provider is in Sanford Health Plan's network. You can do this one of two ways:

1. Call Customer Service toll free at (855) 305-5060 |TTY/TDD: (877) 652-1844.
2. Look for your provider in our directory online at sanfordhealthplan.com.

Check the box below that applies to you:

☐ Yes, my health care provider is in the network. STOP! You do not need to fill out this form.
☐ No, my health care provider is not in the network. Move to Step 2.

STEP 2: Are you are affected by one of the conditions listed below?

- You are in your 2nd or 3rd trimester of your pregnancy;
- A surgery is already scheduled;
- You are getting cancer care (radiation or chemotherapy);
- You are getting organ or tissue transplant services;
- You are getting care, such as mental health care or substance abuse care, and your health care provider thinks it would be harmful to you if you had to change providers;
- You are getting care for a disabling, chronic or severe health issue;
- You have a major physical or mental handicap that has lasted or can be expected to last for at least one year; or
- You are getting care for a terminal illness or hospice (end of life) care.

Check the box below that applies to you:

☐ Yes, I am affected by one of the conditions listed above. Move to Step 3.
☐ No, I am not affected by one of the conditions listed above. STOP! You do not need to complete this form.

STEP 3: Fill out and send the Transition of Care Request Form and mail to Sanford Health Plan by January 31, 2018 in the postage paid return envelope. Sanford Health Plan will review the transition request and we'll send you written notice of our decision.

If you have any questions, please contact Utilization Management Department at (855) 276-7214 for medical requests or Pharmacy Management Department at (855) 263-3547 for pharmacy requests.

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Please print clearly and use a separate form for each condition. Please attach any paperwork or facts that you want us to look at. If you need more space, please use extra paper and send it to us. **Sending us this form does not mean services will be approved or paid for by Sanford Health Plan.**

Member First and Last Name: ____

Member ID number from your ID card: ________________ Date of Birth: ____________

Address: ________________________ City/State: ________________ Zip: ________

Phone Number: __________________________ E-mail: ________________________

Patient's Name: _____________________________________ Date of Birth: ________

Describe health condition: ____

____

When did condition begin? ____

Hospital/Clinic Name: _____________________________Location: ______________

Provider(s) currently involved (list names): ______________________________________

____

Provider(s) Address(es): ________________________ City/State: ___________ Zip: ____

Date of last visit: ________________________ Frequency of visits: _______________

Describe current care or proposed treatment (including surgeries): ______________________

____

____

Expected length of treatment (or date of surgery): _______________________________

____

____

Primary care provider's name: ____

Provider's Address: ________________________ City/State: ___________ Zip: _______

Please read and sign:

I have read and understand the rules for sending this form. I understand that completion of this form does not mean services will be approved or paid for by Sanford Health Plan.

____ ________________

Signature of Patient or Authorized Representative Date Signed