moda 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@modahealth.com

Questions? Contact Moda Health at 888-393-2940 or at medical@modahealth.com

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