Transition of Care/Continuity of Care Request Form

This form should be used to request Transition of Care (TOC) or Continuity of Care (COC) for behavioral health conditions. It can be completed by the patient or their health care provider and requires a patient signature.

INSTRUCTIONS AND ADDITIONAL INFORMATION

- Use this form to submit a request for TOC of mental health or substance use disorder services.
- Use this form to submit a request for COC for mental health or substance use disorder outpatient therapy, medication management, transcranial magnetic stimulation (TMS), applied behavioral analysis (ABA), and intensive outpatient program (IOP). For partial hospitalization (PHP), inpatient (IP), and residential (Res), please call 800.926.2273.
- A separate TOC/COC request form must be completed for each service.
- Claims will be paid at the in-network level for the TOC/COC period only.
- For a network exception request outside of TOC/COC, please visit our Behavioral Health Forms center and submit the appropriate network exception request form based on the type of service.
- Approval of TOC/COC does not change the provider's network status. If interested in becoming a participating Evernorth Behavioral Health provider, please refer to Credentialing for more information.
- For additional information, providers should review the TOC/COC frequently asked questions flyer.

Please complete form and submit:

- **By mail:**
  Evernorth Health Services
  Attn: Outpatient Clinical Support Team
  6625 West 78th Street, Suite 100, Bloomington, MN 55439
- **By fax:** 844.271.1507

ALL FIELDS ARE REQUIRED

Please check the appropriate box:

- ☐ Patient is a new enrollee in the network (TOC applicant)
- ☐ Patient whose health care provider terminated (COC applicant)
- ☐ Patient has been notified by employer that they may qualify for COC (COC applicant)

Employer and patient information

Employer name	Policy number		Date of enrollment in plan *(mm/dd/yyyy)*
Employee name	Member ID		Work phone
Home address	City/ state	ZIP code	Home phone/mobile
Patient name		Patient social security number or alternative ID	
Patient's date of birth *(mm/dd/yyyy)*	Relationship to employee *(please check appropriate box)* ☐ Self ☐ Dependent ☐ Spouse		

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Please answer yes or no for the following questions:

1. Is the patient currently receiving routine outpatient therapy? ☐ Yes ☐ No
2. Is the patient currently receiving medication management services? ☐ Yes ☐ No
3. Is the patient currently receiving ABA services? ☐ Yes ☐ No
4. Is the patient currently receiving TMS? ☐ Yes ☐ No
5. Is the patient currently receiving IOP services? ☐ Yes ☐ No
6. Is the treatment for maternal mental health? ☐ Yes ☐ No
7. Is the treatment for terminal illness? ☐ Yes ☐ No
8. If you did not answer "yes" to any of the above questions, please describe the condition for which the patient requests TOC/COC.

Health care provider information

Group practice name *(if applicable)*	Provider name	
Provider Tax payer Identification Number (TIN)	Provider phone number	
Provider license type	Provider license number	
Service location address	City/state	ZIP code
If ABA, practice address	If ABA, practice phone number	
Diagnostic codes		
Outpatient Current Procedural Terminology (CPT ®) codes		
Treatment start date *(mm/dd/yyyy)*	Requested authorization start date *(mm/dd/yyyy)*	

Evernorth Behavioral Health or its affiliates and contracted parties are hereby authorized access to any and all information and medical records necessary to make an informed decision concerning my request for TOC/COC. It is understood that the patient is entitled to a copy of this authorization request form.

Signature of patient, parent, or guardian	Date *(mm/dd/yyyy)*

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