MercyCare Health Plans™

MercyCare Insurance Company
MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547
WI: (800) 895-2421 IL: (877) 908-6027
MercyCareHealthPlans.com

Transition of Care Request: Pre Enrollment Send to: FAX: 608- 758-7726 OR EMAIL to: mcare@mhemail.org in subject line type QHMD/QHS and attach this form

Completion of this form does not guarantee approval for the requested services. Determinations are individually based on review of care requested & availability of services by a network provider. The determination is mailed to the address provided. **All sections of this form must be completed for review**.

Employer Name: Plan Start Date:

Subscriber Last Name: First Name:
Address: Street: City: State: Zip Code:
Subscriber Phone Number:

***Name of Person Transition of Care being requested for*:**

Last Name: **First Name:** **Middle Initial:**

Date of Birth: **Phone Number of Dependent 18 years or older:**

If this person is 18 years of age or older, we cannot discuss their care, share their protected medical information with anyone but themselves or review their medical records unless we have a signed release from said person. A MercyCare release can be obtained by contacting customer service. A Parent cannot sign a release for their adult children.

☐ 2nd or 3rd Trimester pregnancy Due Date:

☐ Cancer: Type: Type of treatment: (Check all that apply)
☐ Radiation therapy
☐ Chemotherapy: Drug Names:
☐ Surgery/Reconstruction Date of Surgery:
Treatment start date: Expected Treatment end date:

☐ Recent Surgery (last 30 days) Surgery date: Type of surgery:
Post op visit scheduled date(s):
(Physical therapy/rehab visits are expected to be completed in network)

☐Behavioral Health Treatment Number of therapy visits requesting:
Date of last 3 visits.

☐ Other Services: Describe:

*Seeing a provider up to 3 times a year for a chronic or ongoing condition will not be considered

Physician Last Name: First Name:
Physician's Specialty: Clinic Name:
Phone: Address:

Hospital Name:
Hospital Address:

Person Completing Request form: Print Name:

☐ I agree by signing this form, I am permitting access to any clinical or medical records available to Mercycare.

Sign or Type Name: Date:

☐ Granted: Services:

☐ Not Granted: Network Options: