



## TRANSITION OF CARE FORM

In order to facilitate continuity of care for scheduled surgeries or planned procedures, or **complex/chronic conditions** for which you or your dependents are undergoing regular treatment, please complete all the information on this form and mail or fax it to the Health Services Director, Coventry Health Care of Delaware, Inc., **Attn: Transition of Care** at 750 Prides Crossing, Suite 300 Newark, DE 19713 or FAX # **855-301-1572**.

### GROUP EMPLOYER NAME

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### MEMBER NAME

### SOCIAL SECURITY NUMBER

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Last Name, First Name, Middle Initial

### MEMBER NUMBER (if known)

### DATE OF BIRTH

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MM/DD/YY

### DEPENDENT NAME (if applicable)

### RELATIONSHIP/DATE OF BIRTH

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Last Name, First Name, Middle Initial

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Spouse, Child, MM/DD/YY

### ADDRESS

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Street Name, Number, Apt. #

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City, State, Zip code

**DAYTIME PHONE #:** \_\_\_\_\_ **EVENING PHONE #:** \_\_\_\_\_

**If you are currently being treated for a complex or chronic condition or have scheduled procedures, please complete all requested information on this form.**

**Complex or chronic condition being treated (please complete page 3 if you have one of the specific conditions listed):**

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Diagnosis

**Nature and frequency of treatment:** Briefly describe any therapies, treatments, regular appointments, scheduled procedures, prescription drugs, etc., that you are currently receiving or plan to receive and the frequency of such treatment (e.g. daily, weekly, monthly, etc.). Please include any hospitalizations, providing facility name and dates of admission and discharge.

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**TREATING PHYSICIAN**

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Physician Name

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Specialty

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Address 1

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Address 2

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City, State, Zip code

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Phone #

**PRIMARY CARE PHYSICIAN selected with Coventry Health Care (if applicable)**

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Physician Name

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Address 1

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Address 2

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City, State, Zip code

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Phone #

**Other important information or comments about your condition:**

**ASTHMA:**  Y  N Date diagnosed? \_\_\_\_\_

Use peak flow meter?  Y  N Use a spacer?  Y  N

Attending Physician Name & Phone #: \_\_\_\_\_

Please list treatment regimen including medications:

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**PREGNANCY:**  Y  N Anticipated delivery date: \_\_\_\_\_

Pregnancy history:

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Obstetrician Name & Phone #: \_\_\_\_\_

**DIABETES:**  Y  N Diagnosis date: \_\_\_\_\_

Do you use a glucometer to check blood sugars?  Y  N If yes, how often? \_\_\_\_\_

Please list all medications:

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Last blood hemoglobin A1C test: \_\_\_\_\_ Result: \_\_\_\_\_

Physician Name & Phone #: \_\_\_\_\_

**CONGESTIVE HEART FAILURE:**  Y  N Diagnosis date: \_\_\_\_\_

Please list treatment regimen including medications:

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Physician Name & Phone #: \_\_\_\_\_

**RENAL FAILURE OR ON DIALYSIS:**  Y  N Date dialysis started? \_\_\_\_\_

Nephrologist Name & Phone #: \_\_\_\_\_

Dialysis Center Name & Phone #: \_\_\_\_\_

Type of Dialysis: \_\_\_\_\_

Medicare status: \_\_\_\_\_

**Please complete the Transition of Care form:**

1. Placed in a sealed envelope and mail to Coventry Health Care of Delaware, Inc. Attn: **Transition of Care** at 750 Prides Crossing, Suite 300 Newark, DE 19713 or
2. Place in a sealed envelope marked Coventry Health Care of Delaware, Inc., Attn: **Transition of Care** and give to a Coventry representative at the open enrollment meeting; or
3. Fax to Coventry's confidential Health Services number at **855-301-1572**.