



University of
New Haven

Complete and return to: Quantum Health
Fax: 1-888-263-0005
Email: CCHpod2@quantum-health.com

Transition of Care Form

Our goal is to provide benefits for continuity of care for any new member of Quantum who is receiving prenatal care or is in *active treatment for an acute or chronic condition or care from a non-participating provider*. If the member chooses to continue her prenatal care with an out of network provider, the visits may be approved if the member is receiving prenatal care during the second or third trimester of pregnancy and will continue through the provision of post-partum care directly related to the delivery.

If you or any covered family member are receiving care of this kind from a non-participating provider, please complete this form. Information provided will be kept confidential by Quantum and will only be used in accordance with applicable privacy laws. Quantum may share this information with your primary care provider (PCP) and/or specialist and may be in contact with you to facilitate continuity or continuation of care.

Subscriber/Employer Info:

Subscriber Name: _____

Telephone #: _____

Patient Info:

Patient Name: _____ DOB: _____

Telephone #: _____

Patient Address: _____

Provider Info

Primary Care Provider (PCP): _____

PCP Address: _____

PCP Telephone: _____

1) *Specialist Name:* _____

Address: _____

Telephone: _____

2) *Specialist Name:* _____

Address: _____

Telephone: _____

3) *Specialist Name:* _____

Address: _____

Telephone: _____

Brief Description of active treatment being received: _____

Are you working with a nurse case manager with your current Health Plan? Yes/No

Please be advised that Quantum will reach out to you regarding your transition of care.

Signature of Subscriber/Guardian/Parent of the Patient: _____

Date: _____