Transition of Care/Continuity of Care Request Form

CLEAR 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
  9625 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		