North Dakota Medicaid Expansion Transition of Care Request Instructions

Follow the steps below to find out if you should complete this form or not.

STEP 1: Make sure that your health care provider is in Sanford Health Plan's network. You can do this one of two ways:

1. Call Customer Service toll free at (855) 305-5060 | TTY/TDD: (877) 652-1844.
2. Look for your provider in the online provider directory at www.sanfordhealthplan.com.

Check the box below that applies to you:

- ☐ **Yes,** the provider I want to continue seeing is in the Sanford Health Plan network. ⛔ **STOP!** You do not need to fill out this form.
- ☐ **No,** the provider I want to continue seeing is NOT in the Sanford Health Plan network. **Go to Step 2.**

STEP 2: Are you are affected by one of the conditions listed below?

- You are in your 2nd or 3rd trimester of your pregnancy;
- A surgery is already scheduled;
- You are getting cancer care (radiation or chemotherapy);
- You are getting organ or tissue transplant services;
- You are getting mental health or substance abuse care, and your health care provider thinks it would be harmful to you to change providers;
- You are getting care for a disabling, chronic or severe health issue;
- You have a major physical or mental disability that has lasted or can be expected to last for at least one year; or
- You are getting care for a terminal illness or hospice (end of life) care.
- You are receiving services or care which meet your specific cultural and/or language needs

Check the box below that applies to you:

- ☐ **Yes,** I am affected by one of the conditions listed above. **Move to Step 3.**
- ☐ **No,** I am not affected by one of the conditions listed above. ⛔ **STOP!** You do not need to fill out this form.

STEP 3: Fill out and return the included Transition of Care Request Form in the postage paid return envelope within 30 days of your enrollment with Sanford Health Plan.

Sanford Health Plan will review your request and send you a decision in writing.

If you have any questions, please call us toll free at (855) 305-5060 | TTY/TDD: (877) 652-1844.

PO Box 91110
Sioux Falls, SD 57109
(855) 305-5060
Fax: (605) 328-6811
sanfordhealthplan.com

North Dakota Medicaid Expansion Transition of Care Request Form

Please print clearly and use a separate form for each condition. Please attach any paperwork or facts that you want us to look at. If you need more space, please use extra paper and send it to us. **Sending us this form does not mean services will be approved or paid for by Sanford Health Plan.**

Member First and Last Name: ____

Member ID number from your ID card: ________________________ Date of Birth: ________________

Address: __________________________________ City/State: ______________________ Zip: __________

Phone Number: ___________________________ E-mail: ______________________________________

Describe health condition needing transition of care assistance: _________________________________

____

When did condition begin? ____

Provider(s) currently involved (list names) in treating you: _____________________________________

____

Provider(s) Address(es): _________________________ City/State: _________________ Zip: __________

Date of last visit: ________________________ Frequency of visits: _____________________________

Describe current care or proposed treatment (including surgeries and planned inpatient stays): __________

____

Expected length of treatment (or date of surgery): ____

____

Hospital/Clinic Name(s): _______________________________Location(s): ________________________

____

Primary care provider's name (if you have one): ____

Provider's Address: ___________________________ City/State: _________________ Zip: ____________

Do you have cultural and/or language needs you want considered during your transition of care?

☐ No ☐ Yes – If yes, please explain: ____

Please read and sign: I have read and understand the rules for sending this form. I understand that completion of this form does not mean services will be approved or paid for by Sanford Health Plan.

____ ____________________

Signature of Member or Authorized Representative Date Signed