Medical Management Transition of Care Form

If you or a member of your family are undergoing medical treatment or are pregnant, please fill out this form and send it to us within 30 days of your new enrollment date. Complete one form for each family member, as needed.

All information provided on this form is confidential and used only for coordinating medical care. This form does not guarantee coverage of benefits and services. All services with non-participating providers must be authorized by Aspirus Health Plan prior to services being provided. Benefit coverage and eligibility are determined at the time of claim submission. For questions or more information, please contact the Medical Management Team at 866.631.5404

Please mail or fax your completed form to:
Aspirus Health Plan
Attn: Medical Management Transition Form
PO Box 1062
Minneapolis, MN 55440
Fax: 763.847.4010

MEMBER INFORMATION

YOUR EMPLOYER'S NAME	
SPOUSE	DATE OF BIRTH
DEPENDENT NAME	DATE OF BIRTH
PHONE	EMAIL

MEDICAL INFORMATION

PHYSICIAN NAME	PHONE
ADDRESS	

REASON FOR TRANSITION OF CARE

☐ MEDICAL ☐ PREGNANCY. DUE DATE: ________________ ☐ MENTAL HEALTH ☐ OTHER

PLEASE DESCRIBE CONDITION/TREATMENT:

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