Medical Management Transition of Care Form

Complete one form for each family member, as needed, and return to your Aspirus Health Plan Account Manager. You will receive a letter with an approval or denial of your request.

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.

Email your completed form to: ______________________________ **by** ______________

MEMBER INFORMATION

Your Employer's Name			
Employee Last Name	Employee First Name	MI	Employee Date of Birth
Who is the request for? *(First and Last Name)*			Date of Birth
Contact Person Last Name	Contact Person First Name		Contact Person Phone Number
Contact Person Email Address			

MEDICAL INFORMATION

Physician Last Name	Physician First Name		
Clinic Name			Clinic Phone Number
Clinic Address	City	State	Zip Code

REASON FOR TRANSITION OF CARE

☐ Medical ☐ Pregnancy Due Date: ______________ ☐ Mental Health ☐ Other

Please describe condition/treatment:

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