Request for Transition of Care

Aetna Better Health Premier Plan MMAI

Date: ______________________ Completed by: ____________________________

Provider Information

Provider Name: ____

Group/Facility Name: ____

Provider NPI: ________________________ Provider Phone: __________________________

Member Information

Member Name: ____

Member ID: ____________________________ Date of Birth: ___________________________

Member Address: ____

Service Information

Type of Service: ____

Current Service End Date: ____

Diagnosis: ____

Continuity of Care Concern: ____

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Proprietary

Service Information Continued

Type of Service: ____

Current Service End Date: ______________________________________

Diagnosis: ____

Continuity of Care Concern: _____________________________________

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Type of Service: ____

Current Service End Date: ______________________________________

Diagnosis: ____

Continuity of Care Concern: _____________________________________

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Service Information Continued

Type of Service: ____

Current Service End Date: ____________________________________

Diagnosis: ____

Continuity of Care Concern: ___________________________________

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Type of Service: ____

Current Service End Date: ____________________________________

Diagnosis: ____

Continuity of Care Concern: ___________________________________

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Thank you for taking the time to complete this form and assisting us in providing you with a smooth transition of care.

Please mail or fax this form to:

Aetna Better Health Premier Plan MMAI
ATTN: Utilization Management
3200 Highland Avenue F661
Downers Grove, IL 60515
Fax: 855-687-6955

Aetna Better Health Premier Plan MMAI is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

Proprietary

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website at or call the phone number listed in this material.

In addition, your health plan provides auxiliary aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Your health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, call Customer Service at the phone number on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf.

ESPAÑOL (SPANISH): Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

繁體中文 **(CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。