

Utilization Management	Effective Date: 02/28/2012 Last Revised Date: 12/20/2011
Subject Transition of Care Coverage Policy California Amendment for HMO Plans	Originating Dept. Regional Quality Management Signature Authority: NQOC Chairperson

Applies to Department:	<input checked="" type="checkbox"/> PM	<input checked="" type="checkbox"/> Precertification	<input checked="" type="checkbox"/> NME	<input checked="" type="checkbox"/> WH	<input checked="" type="checkbox"/> BH
Product:	<input checked="" type="checkbox"/> HMO	<input type="checkbox"/> EPO	<input type="checkbox"/> PPO	<input type="checkbox"/> MC/POS	<input type="checkbox"/> TC
Type:	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Revision	<input type="checkbox"/> Replacement	<input type="checkbox"/> Review – No changes	<input checked="" type="checkbox"/> EAP

Purpose:

This amendment is written to meet regulatory and statutory requirements under the California Health & Safety Code 1373.96 that impact Transition of Care Coverage Policy.

Background:

There are California requirements that deviate from or exceed those detailed in Transition of Care Coverage Policy, NCM 600-01. This amendment will be used in conjunction with the NCM 600-01 to comply with California requirements.

Definitions:

- CA Health & Safety Code 1373.96(k)(1) (HMO): "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
- CA Health & Safety Code 1373.96(k)(2) (HMO): "Nonparticipating provider" means a provider who is not contracted with a health care service plan.
- CA Health & Safety Code 1373.95(e)(2) (HMO): "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed professional clinical counselor or licensed social worker who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.
- CA Health & Safety Code 1373.96(k)(4) (HMO): "Provider group" means a medical group, independent practice association, or any other similar organization.
- CA Health & Safety Code 1373.96(k)(3) (HMO): "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.
- CA Health & Safety Code 1373.95(e)(1) (HMO): "Hospital" means a general acute care hospital. A hospital is also a "provider" for purposes of this policy.

Scope:

These requirements apply when eTUMS shows the Controlling State as CA.

00.29.302.1-CA-H

California HMO Amendment to Policy NCM 600-01 & Procedure 600-02

This policy applies to all fully-insured HMO products except Medicare Advantage. Members whose plan sponsor is switching to coverage provided by the Aetna Value NetworkSM HMO are considered to be renewing in a different Aetna Health plan even if their Covered Benefits remain the same. ASC plans are excluded from this policy.

Attachment A – California HMO Transition Coverage Request Form

Policy:

- A. In order to provide for continuity of care for members and in accordance with California Health & Safety Code 1373.96, Aetna shall provide the completion of covered services for conditions listed in Section B below. Completion of the covered services shall occur in the following circumstances:
- Terminated Provider – For an enrollee who, at the time of the provider’s contract termination, was receiving services from that provider for one of the conditions described below.
 - Nonparticipating provider – For a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described below.
- B. The conditions for which Aetna will provide for the completion of covered services are:
1. An acute condition. An acute condition is a medical condition that involves the sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. **Completion of covered services shall be provided for the duration of the acute condition.**
 2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. **Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date for a newly covered enrollee.**
 3. A pregnancy. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. **Completion of covered services shall be provided for the duration of the pregnancy and the immediate postpartum period.**
 4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. **Completion of covered services shall be provided for the duration of a terminal illness.**
 5. The care of a newborn child between birth and age 36 months. **Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.**
 6. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment to occur **within 180 days of the contract’s termination date or within 180 days of the effective date of coverage for a newly covered enrollee.**
 7. Behavioral Health. Aetna will facilitate continuity of care for a new enrollee whose employer has changed health plans and who has been receiving services from a nonparticipating mental health provider for an

acute, serious, or chronic mental health condition. **The enrollee shall be allowed a reasonable transition period to continue his or her course of treatment with the nonparticipating provider and shall include the provision of mental health services on a timely, appropriate, and medical necessary basis from the nonparticipating provider.**

- a. Aetna will take into account, on a case by case basis, the length of the transition period, the severity of the enrollee's condition, and the amount of time reasonably necessary to effect a safe transfer to a participating provider. Reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition.
- b. Aetna is not required to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees.
- c. For purposes of the continuing treatment of the transferring enrollee, Aetna may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.
- d. Aetna may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment.
- e. If Aetna determines that an enrollee's health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, Aetna shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.
- f. The policy shall not apply to an enrollee who is offered an out-of-network option.
- g. Employee Assistance Program (EAP) - Aetna will facilitate continuity of care for a new enrollee whose employer has changed to Aetna EAP and who has been receiving services from a nonparticipating mental health provider.
 - If the provider either declines the rate or compliance with EAP procedures, the member is offered an in network EAP option.

C. Contractual Considerations

1. Unless otherwise agreed by the terminated provider or the nonparticipating provider and Aetna or by the individual provider and the provider group, the services rendered shall be compensated at rates and methods of payment similar to those used by Aetna or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider or the nonparticipating provider.
2. The amount of, and the requirement for payment of, co-payments, deductibles, or other cost-sharing components by the enrollee during the period of completion of covered services with a terminated provider or a nonparticipating provider shall be the same co-payments, deductibles and other cost-sharing components that would be paid by the enrollee when receiving care from a provider currently contracting with Aetna.
3. Aetna may require the nonparticipating provider whose services are continued for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in

California HMO Amendment to Policy NCM 600-01 & Procedure 600-02

the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Neither Aetna nor the provider group is required to continue the provider's services if the nonparticipating provider does not agree to comply or does not comply with the contractual terms and conditions.

4. Aetna may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the health plan or insurer is not required to continue the provider's services beyond the contract termination date.

D. Aetna is not required to provide for the completion of covered services in the following instances:

1. For a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.
2. For services or benefits that are not otherwise covered under the terms and conditions of the plan contract.
3. To a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in section (B) above.
4. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, then the plan is not required to continue the provider's services beyond the contract termination date.
5. Neither Aetna nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

E. Additional Considerations and Requirements

1. The provisions contained in this policy are in addition to any other responsibilities of Aetna to provide continuity of care. Nothing in this policy shall preclude Aetna from providing continuity of care beyond the requirements of this section.
2. Decisions regarding Transition Coverage Requests are made within two (2) business days of obtaining all necessary information. Members with urgent/emergent requests regarding acute conditions may call Member Services, request the Transition Coverage Request Form, and fax it to Patient Management at the number provided on the form. Decisions regarding urgent/emergent requests are made on the same business day on which they are received. Reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider. The provider is notified telephonically within twenty-four (24) hours of the decision. The enrollee and the terminated or nonparticipating provider are notified of the decision in writing within two (2) business days of the decision. If services were received prior to the approval of transition of benefits, the services must be approved by the Medical Director in order for coverage to be extended at the new plan level. The Medical Director considers delays incurred by the Plan which may have affected the enrollee's receipt of services prior to the approval of transition coverage.

California HMO Amendment to Policy NCM 600-01 & Procedure 600-02

3. As communicated in the Disclosure Notice and Evidence of Coverage at pre-enrollment, Aetna provides all new enrollees with notice of this policy as well as how to request a Transition of Care review. The enrollee must request a Transition Coverage Request Form by calling the Member Services telephone number listed on the ID card. The form must be submitted by the enrollee within 90 days after the enrollment or re-enrollment period or within 90 days from the date of discontinuation of the provider's contract and prior to receiving services (except in an emergency) from the non-participating provider. Request Forms may also be obtained from the enrollee's employer.
4. Aetna shall provide a written copy of this policy to its enrollees upon request. Members may request a copy of the information by calling the Member Services telephone number listed on the ID card and requesting a copy of the Transition of Care Coverage Policy.
5. Aetna does not delegate the responsibility of complying with these requirements to a provider group and/or its contracting entities.
6. Aetna is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.
7. When a provider group or hospital terminates its contract, Aetna takes the following steps to transfer the enrollees to another participating provider group or hospital:
 - For block transfers, Aetna provides 75-days written notice to the CA Department of Managed Health Care in advance of the termination date. The notice includes the Department's Form A (Provider Group Terminations) or Form B (Hospital Terminations), as applicable.
 - For provider group terminations, Provider Data Services generates an enrollee re-assignment report by the enrollees' proximity to other participating Primary Care Physicians (PCPs) with the capacity to accept new members. Proximity is determined in accordance with the Department of Managed Health Care's geographic access standards. After verifying that the PCPs' Participating Medical Group (PMG) or Independent Physicians Association (IPA) administrative and financial capacity to handle a block transfer, Network Management staff obtains agreement from the PMG or IPA to accept this assignment of enrollees. Provider Data Services generates enrollee notification letters that communicate information about the termination and the re-assignment of enrollees to other participating PMGs/IPAs. Enrollee notification letters are mailed 60 days in advance of the termination date. Patient Management Delegation nurses obtain the roster of enrollees who have been authorized for services by the terminating PMG/IPA. Regional Patient Management compares this roster against incoming Transition of Care Coverage Request Forms to verify the procedure and treatment being requested by enrollees.
 - For hospital terminations, Network Management generates a report to identify providers with admitting privileges to that hospital. These providers are instructed in writing to notify Aetna, via the Transition of Care Coverage Form, of any enrollee who requires continuity of care. Network Management ensures that alternate hospitals meet the DMHC's geographic standards and have the same range of services as the terminating hospital. Provider Data Services sends enrollee notification letters to all members residing within 15 miles of the terminating hospital. These notices are mailed to enrollees pursuant to regulatory requirements regarding timeframes.
 - For terminations of individual providers who are contracted with provider groups, the provider group notifies Network Management of the termination. The provider group also designates the new individual provider to whom members will be assigned and Network Management implements those assignments. Provider Data Services then sends the member notices 60 days in advance of the termination date.
 - For terminations of individual providers who are contracted directly with Aetna, Network Management receives and processes the termination notice. Network Management then contacts one or more individual providers to verify that those providers can assume responsibility for the members assigned to the terminating provider. Upon verification, Network Management reassigns the members and Provider Data Services sends the member notices 30 days in advance of the termination date.

California HMO Amendment to Policy NCM 600-01 & Procedure 600-02

- When anticipated provider terminations do not occur, Network Management notifies Provider Data Services, which notifies the affected enrollees within 20 business days of the option to return to the original provider.
 - If Aetna cannot notify the DMHC and/or enrollees within the required timeframes due to exigent circumstances, then it will apply to the DMHC for a waiver.
8. Aetna sends notices to enrollees that describes the Transition of Care Coverage policy and informs enrollees of their right to completion of covered services when provider groups and hospitals terminate. These notices are sent to enrollees 60 days in advance of the termination date. Templates of these enrollee notices have been approved by the CA Department of Managed Health Care. If a provider or provider group contract does not terminate, then Aetna sends a notice to enrollees within 20 business days, which offers the member the option to return to the original provider/provider group.



Transition Coverage Request

Personal and Confidential

This form applies to fully insured commercial HMO members in California.

On the other side of this form, you'll find answers to commonly asked questions about transition-of-care coverage. Please read them before filling out this form.

This is a request for Aetna to cover ongoing care at the highest level of benefit from:

- An **out-of-network doctor**;
- A **doctor whose network status has changed**;
- **Certain other healthcare providers** who have treated you.

Once we review your completed form, we will send you a letter outlining our decision regarding your request for transition-of-care coverage.

Step 1: Fill out these sections:

1. Section 1 - Employer Information.
2. Section 2 - Subscriber and Patient Information (Aetna plan information is found on the front of the Aetna ID card).
3. Section 3 - Authorization: Read the authorization, then sign and date the form. (If patient is age 17 or older, he/she must also sign and date this form.)

Step 2: Give the form to the doctor to complete Section 4.

Step 3: Fax the completed form to Aetna for review. **Note:** Complete one form for each out-of-network provider.

NOTE: A request for transition of coverage **does not** apply to Aetna's in-network (participating) providers. The DocFind® online provider directory is at www.aetna.com. It can tell you if your doctor is in the network or help you find a participating provider for your Aetna plan. You can also call us at the phone number on your Aetna ID card.

Fax medical requests to: 1-800-228-1318

Fax mental health/drug/alcohol abuse requests to: 1-860-754-2532

Be sure to complete all fields on page 4 when submitting this form. It will speed up processing of your transition-of-care request.



Aetna Transition of Care Coverage Questions and Answers California Commercial HMO and Traditional Fully Insured Products

Q. What is transition-of-care (TOC) coverage?

A. TOC facilitates minimal disruption and permits a member to continue care for a transitional period of time, without penalty, at the preferred plan benefit level. TOC coverage applies to the following types of providers: an individual practitioner, a medical group, an independent practice association, an acute care hospital, or an institution licensed in California and that delivers or furnishes health care services. Examples of individual practitioners include doctors, psychiatrists, and licensed therapists.

In California, transition coverage is provided under certain circumstances for the completion of covered services for the following conditions:

- Pregnancy which includes the 3 trimesters of pregnancy and the immediate postpartum period.
- An acute condition that involves the sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- Previously scheduled surgery or other procedure authorized by Aetna that is part of a documented course of treatment with documentation that the provider recommends the treatment to occur within 180 days of the provider's contract termination date or within 180 days of the effective date of a newly covered enrollee.
- A terminal illness which is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
- A chronic medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan, in consultation with the member, the nonparticipating or terminated provider, and consistent with good professional practice, not to exceed 12 months from the contract termination date or 12 months from the effective date of a newly covered enrollee.
- Any services related to the care of a child ages 0-36 months up to 12 months from the provider's contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
- Behavioral Health services for HMO members who are receiving outpatient treatment for a mental illness or for substance abuse. (The member must have had at least one (1) treatment session within 30 days prior to the status change date of either the member or the Aetna participating provider). In addition, for HMO members with no out-of-network benefit, Aetna will facilitate continuity of care for a new enrollee whose employer has changed health plans and who is receiving treatment from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition for the amount of time reasonably necessary to effect a safe transfer to a participating provider.

To be considered for TOC coverage the course of treatment for the conditions listed above must have started before the enrollment or re-enrollment date, or before the date your doctor left the Aetna network, or before the date of a doctor's network status change for new enrollees or prior to a provider's termination date for existing members.

Q. When does California transition coverage apply and when does Aetna transition coverage apply?

A. Below are the four possible situations when transition coverage will be considered:

- California TOC – You are a **newly covered member of an Aetna HMO medical** benefit plan and the provider from whom you are receiving services for one of the conditions described above is not a participating provider in your new Aetna plan. Members whose plan sponsor is switching to coverage provided by the Aetna Value NetworkSM HMO are considered to be renewing in a different Aetna Health plan even if their Covered Benefits remain the same.
- California TOC – You are an existing member of an **Aetna HMO plan and your participating provider terminates a contract with Aetna** while you were receiving services from that provider for one of the conditions described above at the time of the provider's contract termination.
- California TOC – You are an existing member of an **Aetna Traditional (non-HMO) plan and your participating provider terminates a contract with Aetna** while you were receiving services from the provider for one of the conditions described above at the time of the provider's contract termination.
- Aetna Standard TOC – You are a **newly covered enrollee of a Traditional (non-HMO) plan** and:
 - Your provider is not in the Aetna network; or,
 - Your provider leaves the Aetna network; or,
 - Your provider's Aexcel network status changes, which affects your benefits; or,
 - Your provider is not included in the Aexcel network and your benefits change to include the Aexcel network.

For **Traditional members newly enrolled in an Aetna Traditional (non-HMO) plan**, Aetna Transition of Care Coverage is considered for an active course of treatment, meaning that you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some examples may include, but are not limited to:

- Members who enroll with Aetna beyond 20 weeks of pregnancy. Members less than 20 weeks pregnant whom Aetna confirms as high risk are reviewed on a case-by-case basis
- Members who have completed 14 weeks of pregnancy or greater and are receiving care from an Aetna participating practitioner who undergoes an Aexcel network status change
- Members in an ongoing treatment plan, such as chemotherapy or radiation therapy
- Members with a terminal illness, expected to live six months or less
- Members who need more than one surgery, such as cleft palate repair
- Members who have recently had surgery
- Members who receive outpatient treatment for a mental illness or for substance abuse. (The member must have had at least one treatment session within 30 days prior to the status change date of either the member or the Aetna participating practitioner.)
- Members with an ongoing or disabling condition that suddenly gets worse;
- Members who may need or have had an organ or bone marrow transplant.

For Traditional members newly enrolled in an Aetna plan, Aetna Standard TOC coverage typically lasts 90 days, but this may vary based on your condition (for example, pregnancy).

To be considered for TOC coverage, the course of treatment must have started before the enrollment or re-enrollment date, or *before* the date your doctor left the Aetna network, or *before* the date of a doctor's Aexcel network status change.

Q. What other types of providers, besides doctors, can be considered for TOC coverage?

A. This includes health care professionals such as physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services such as visiting nurses. Providers considered for transition coverage may vary by condition, as described above, in accordance with California law. California TOC does not apply to durable medical equipment (DME) vendors or pharmacy vendors. Aetna Standard TOC does not apply to other health care facilities (for example, skilled nursing facility) DME vendors or pharmaceutical items. TOC is considered for participating facilities only when the facility is not designated as a Choose and SaveSM (tier 1) facility or a Savings Plus provider (tier 1) and the member's plan includes these low-cost networks.



Aetna Transition of Care Coverage Questions and Answers California Commercial HMO and Traditional Fully Insured Products

- Q. If I am currently receiving treatment from my doctor, why wouldn't my request for California TOC coverage or for Aetna Standard TOC coverage be approved?
- A. In addition to currently receiving treatment, your request must involve a covered procedure/service. Your doctor must also agree to accept the terms outlined on the TOC Request form.
- Q. My PCP is no longer an Aetna provider. If my plan requires me to select a PCP, can I still see my doctor?
- A. If you are currently receiving treatment, you may still be able to visit your PCP, even if he/she leaves the network. Talk to your PCP so that he/she can help you with your future health care needs.
- Q. How long does TOC coverage last?
- A. Please refer to the above question, what is transition-of-care (TOC) coverage?
- Q. How do I sign up for TOC coverage?
- A. Contact your employer or Aetna Member Services. You must submit a Transition Coverage Request form to Aetna:
- Within ninety (90) days of when you enroll or re-enroll
 - Within 90 days of the date the provider left the Aetna network
 - Within 90 days of a doctor's Aexcel network status change.
- You or your doctor can send in the request form.
- Q. How will I know if my request for TOC coverage is approved?
- A. You will receive a letter via U.S. mail. The letter will say whether or not you are approved.
- Q. Does TOC coverage apply to the Traditional Choice® Plan?
- A. No. This plan does not have a provider network.
- Q. What if I have an Aexcel plan?
- A. If TOC coverage is approved, you can still receive care at the highest benefit level for a certain time period. If you continue treatment with a doctor who is not part of the Aexcel network, or a doctor whose Aexcel network status changes after the approved time period, your coverage would follow what is stated in your plan design. This means you may have reduced benefits or no benefits.
- Q. What if I have more questions about transition-of-care coverage?
- A. Call the Member Services phone number on your Aetna ID card. If you have questions about TOC mental health services, you can call the Member Services phone number on your Aetna ID card or, if listed, the mental health or behavioral health phone number.



Transition Coverage Request

Personal and Confidential

This form applies to fully insured commercial HMO members in California.

1. Employer Information (Note: Please complete a separate form for each member and or provider.)

Employer's Name (please print)	Plan Control Number	Plan Effective Date (Required)
--------------------------------	---------------------	--------------------------------

2. Subscriber and Patient Information

Subscriber's Name (please print)	Subscriber's Aetna Number	
Subscriber's Address (please print)		
Patient's Name (please print)	Birthdate (MM/DD/YYYY)	Telephone Number
Patient's Address (please print)	Plan Type/Product	

3. Authorization

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with Aetna, or before the end of the provider's contract with the Aetna network, or before the provider's Aexcel network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain limited period of time. I give permission for the health care provider to send any needed medical information and/or records to Aetna so a decision can be made.

Patient's Signature (Required if Patient is 17 or Older)	Date (MM/DD/YYYY)
Parent's Signature (Required if Patient is 16 or Younger)	Date (MM/DD/YYYY)

4. Doctor Information

Name of Treating Doctor or Other Healthcare Provider (please print)		Telephone Number
Address of Treating Doctor or Other Healthcare Provider (please print)		Hospital (if applicable)
Please provide all specific information to avoid delay in the processing of this request.		

Misrepresentation: Attention California Residents: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

DMHC Written Notice of Availability of Language Assistance

HMO and DMO@-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at **1-877-287-0117**.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al **1-877-287-0117**.