Document ID: AETCSPS-073174	**Title:** National Clinical Services (NCS) 600 Transition/Continuity of Care Coverage – California HMO Plan	
Parent Documents: Document ID of National policy		
Effective Date: See Document Information Page	**Last Review Date:** See Review and Revision History Section	**Business Process Owner (BPO):** Sr Mgr,Health Care Quality, CS NQM Quality Operation
Exhibit(s): Exhibit 1, California HMO Transition Coverage Request Form		
Document Type: Tool		

Effective Date: 11/19/2024
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PURPOSE

We wrote this amendment to meet regulatory and statutory requirements under the California Health & Safety Code 1373.96,1373.95 (a)(1)(2)(3), Rule 1300.67.1.3, and APL 19-013 that impact Transition/Continuity of coverage policy and procedure.

SCOPE

Applies to Department:	■ Care Management	■ Precertification (including NME, SCPU, Specialty Medical Precert)	■ NME Case Management
■ 24-Hour Nurse Line	■ DM	■ BH	■ Aetna Women's Health Program

Product:	■ HMO	☐ EPO	☐ PPO	☐ MC/POS	☐ TC	☐ JV

These requirements apply when the controlling state is California. This policy applies to all fully insured commercial HMO products.

POLICY

A. In order to provide for continuity of care for members and in accordance with California Health & Safety Code 1373.96, the plan will provide the completion of covered services for conditions listed in Section B below. Completion of the covered services will occur in the following circumstances:
   - Terminated provider – For an enrollee who, at the time of the provider's contract termination, was receiving services for one of the conditions below from a provider whose contract ended. Please note a terminated provider could be a provider as defined above who terminates from an IPA or medical group that was never participating with the health plan.
   - 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 medical, mental health or substance use conditions for which the plan will provide for the completion of covered services are:

1. An acute condition. An acute condition involves the sudden onset of symptoms due to an illness, injury, or other medical, mental health or substance use problem that requires prompt medical attention and that has a limited duration. **Completion of covered services will be provided for the duration of the acute condition.**

2. A serious chronic condition. A serious chronic condition is a result of a disease, illness, or other medical, mental health or substance use problem or medical disorder. It is serious in nature and 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 Provider's contract termination date or 12 months from the effective date for a newly covered enrollee.**

3. 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.**
   Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
   An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider.
   Completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

4. 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 be covered, the surgery or other procedure has

to take place **within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.**

C. Contractual considerations

1. Unless otherwise agreed by the terminated provider or the nonparticipating provider and the plan 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 the plan 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 the plan.

3. The plan 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 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 the plan 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. The plan 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. The plan 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. 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.

4. Neither the plan 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 the plan to provide continuity of care. Nothing in this policy shall preclude the plan 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. Necessary information includes a completed Transition of Care form and information required by the form. 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.

3. As communicated in the Disclosure Notice and Evidence of Coverage at pre-enrollment, the plan 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. The plan may make an exception to the 90-day timeframe for an extenuating circumstance. Examples could be the member was affected by a natural

disaster, the member had an extended inpatient stay, etc. The plan would ask the member to describe their extenuating circumstance.

4. The plan 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. The plan does not delegate the responsibility of complying with these requirements to a provider group and/or its contracting entities.

6. The plan 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, the plan takes the following steps to transfer the enrollees to another participating provider group or hospital:
   - For block transfers, the plan 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. Clinical Health Services Patient Management Delegation nurses review the group terminations for TOC and obtain the roster of enrollees who have been authorized for services by the terminating PMG/IPA.
   - 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 the plan, 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 60 days prior to the termination.
   - 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 the plan, 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.
- 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 the plan 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. The plan 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. **See link** for templates of these enrollee notices https://www.aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html that have been approved by the CA Department of Managed Health Care. If a provider or provider group contract does not terminate, then the plan sends a notice to enrollees within 20 business days, which offers the member the option to return to the original provider/provider group.

9. Material changes to this policy will be filed with the California Department of Managed Health Care.

STATE DEFINITIONS

- "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(n)(1) (HMO)
- "Nonparticipating provider" means a provider who is not contracted with a health care service plan. CA Health & Safety Code 1373.96(n)(3) (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 1373.95(e)(2) (HMO)
- "Provider group" means a medical group, independent practice association, or any other similar organization. CA Health & Safety Code 1373.96(n)(5) (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 1373.96(n)(4) (HMO)
- "Hospital" means a general acute care hospital. A hospital is also a “provider” for purposes of this policy. CA Health & Safety Code 1373.95(e)(1) (HMO)
- “Pharmaceutical items” means medications that are used to diagnose, cure, treat, or prevent disease (plan definition)

EXHIBIT(S): Exhibit 1, California HMO Transition Coverage Request Form

Transition/Continuity Coverage Request ECHS Category - TCRF

Personal and confidential

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

Here's the form you requested for transition-of-care/continuity of care coverage from the health plan. If we approve your request, the health plan will cover ongoing care at the highest level of benefits from:

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition-of-care/continuity of care coverage
You'll find answers to commonly asked questions about transition-of-care/continuity of care coverage on the other side of this form.
You should read them before filling out this form.

Transition-of-care/Continuity of Care coverage does not apply if your provider is in the plan's network (participating). The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

How to complete the form and get it to us
Step 1**:** Fill out these sections:

1. Section 1 - Member, Group or Employer Information.
2. Section 2 - Subscriber and patient Information: Plan information is on the front of your ID card.
3. Section 3 - Authorization: Read the authorization, then sign and date the form.

Step 2**:** Give the form to the doctor/health care provider to complete Section 4 on page 4, including the diagnostic and treatment information requested on **page 5**.

Step 3**: Fax** or email the completed form to us for review. You should complete one form for each health care provider.

Fax medical requests to 1-859-455-8650. Send email requests to VFAXPrecert@aetna.com.
Fax mental health/substance abuse requests to 1-888-463-1309.

Be sure to complete all fields on page 5 before you submit this request form.
Your request will be answered faster that way.

Transition of care/Continuity of Care coverage questions and answers

California Commercial HMO Fully Insured Products

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

A. For new members:

TOC/COC coverage is temporary. You can get TOC/COC when you become a new member of a medical benefits plan or change your plan, and you are being treated for a medical, mental health or substance use condition by a doctor who:

- is not in the plan's network
- is not included in a Narrow Network, or plan sponsor specific network, and your benefits change to include one of these networks.

TOC/COC coverage can also apply when your doctor leaves the plan's network or changes network status. Approved TOC/COC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

TOC/COC coverage applies to these types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to provide health care services.
Examples of individual practitioners include doctors, psychiatrists licensed therapists, and qualified autism service providers, professionals or paraprofessionals.

If you want to get covered DME or pharmaceuticals from a specific vendor that is outside the Plan's network, a TOC/COC form is not required for DME vendors or Pharmacy vendors. Please call the Member Services phone number on your ID card or your provider can contact our precertification department. Visit **Aetna.com/ProviderPrecertificationList** to learn more. We will process requests for non-participating DME vendors and pharmacy vendors according to your plan documents.

For existing members:

TOC/COC coverage can also apply when your doctor or facility leaves the plan's network or changes network status. Approved TOC/COC coverage allows a member who is receiving treatment to continue the treatment **for a limited time**
at the highest plan benefits level.

TOC/COC coverage applies to these types of providers: individual practitioners, medical groups, independent practice associations, acute care hospitals, or institutions licensed in California to provide health care services.
Examples of individual practitioners include doctors, psychiatrists licensed therapists, and qualified autism service providers, professionals or paraprofessionals.

If you want to get covered DME or pharmaceuticals from a specific vendor that is outside the Plan's network, a TOC/COC form is not required for DME vendors or Pharmacy vendors. Please call the Member Services phone number on your ID card or your provider can contact our precertification department. Visit **Aetna.com/ProviderPrecertificationList** to learn more. We will process requests for non-participating DME vendors and pharmacy vendors according to your plan documents.

Q. What is an active course of treatment?

A. An active course of treatment means you have been receiving services from 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 active course of treatment examples may include but are not limited to members who:

- Are pregnant and has begun a course of treatment (including prenatal care) for the pregnancy from the provider or facility. Pregnancy is the three trimesters of pregnancy and the immediate postpartum period.
    - Maternal mental health condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.
    - An individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider. **Completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later**.
- Have an acute condition that involves the sudden onset of symptoms due to an illness, injury, acute, serious mental illness or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for the duration of the acute condition.
- Are authorized to undergo a surgery or procedure from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery. The documentation must show that the provider recommends the treatment to occur within 180 days of the provider's contract termination date or within 180 days after the effective date of the newly covered enrollee.

Continued on the next page.

- Have a terminal illness that is an incurable or irreversible condition and that has a high probability of causing death within one year or less. Completion of covered services will be provided for the duration of the terminal illness.
- Have an on-going or disabling medical condition or serious or chronic mental illness 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 will 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. Coverage will not exceed 12 months from the contract termination date or 12 months from the effective date of a newly covered enrollee.
- Are undergoing a course of treatment for an acute or serious chronic condition from a provider or facility, such as chemotherapy or radiation therapy
- Are receiving 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.
- May need or have had an organ or bone marrow transplant

Q. Do I need to complete a form for each provider that I am requesting TOC/COC for?

A. Yes, a separate form is required for each provider.

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

A. TOC/COC coverage may also apply to physical therapists, occupational therapists, speech therapists, and agencies that provide skilled home care services, such as visiting nurses. TOC/COC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks or when a participating facility terminates from the network. Providers considered for transition coverage may vary by condition, as described above, in accordance with California law.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for California TOC/COC coverage?

A. To be approved for TOC/COC, the procedure or service must be a covered benefit under the terms of your plan. **For providers that leave the network:** your doctor must accept the terms outlined in this TOC/COC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're currently receiving treatment (as described above), you may still be able to visit your PCP, even if your PCP leaves the network. If not, you may need to select a new PCP in the health plan's network. Talk to your PCP for help with your future health care needs.

Q. How do I sign up for TOC coverage?

A. Contact the Member Services number on your member ID card. You must submit a TOC/COC Request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the plan's network or within 90 days from the date on the letter notifying you of the change
- Within 90 days of a doctor's network status change

You or your doctor can send in the request form

Q. What if I have a Narrow Network or plan sponsor specific network plan?

A. If we approve your TOC/COC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC/COC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC/COC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health phone number.

Q. How will I know if my request for TOC/COC coverage is approved?

A. You will receive a letter by U.S. mail. The letter will say whether or not you are approved

Transition/Continuity Coverage Request ECHS Category - TCRF

Personal and confidential

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

☐ **Medical** ☐ **Mental health/substance abuse**

Please indicate above whether this request is for medical treatment or mental health/substance abuse treatment.

Please complete this form to the best of your ability. Your request for continued coverage will not be denied if sections are left blank or your treating provider does not fill out the form.

1. Group or employer information (Note: Complete a separate form for each member and or provider.)

Plan, Group or employer's name (please print)	Plan number(s)	Plan effective date **(required)**

2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID 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	
Telephone number for patient/subscriber submitting request (Business hours, 9 a.m. – 5 p.m.)		
Request for Transition of Care due to: **New member:** ☐ Yes ☐ No **Provider termination:** ☐ Yes ☐ No **If provider termination,** please provide the date of the letter notifying you of the provider terminating from the network and include a copy of the letter with the completed form. *(MM/DD/YYYY)*		

3. Authorization

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's 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 the health plan 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. Provider information

Name of treating doctor or other health care provider (please print)	Tax ID number
Service Address of treating doctor or other health care provider (Please print)	
Contact name of office personnel to call with questions	Telephone number
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation." Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not to seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use the health plan' network for any referrals, lab work or hospitalizations for services not part of the requested treatment.

Transition/Continuity Coverage Request

ECHS Category - TCRF

Personal and confidential

Patient's name (please print)	Birthdate *(MM/DD/YYYY)*

Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY

Are you in a current course of active treatment (Reconstruction Surgery, Radiation Therapy, Immunotherapy, Targeted Agents, **OR** Chemotherapy) for Cancer with treatment initiated in the last 90 days?

☐ Yes ☐ No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next Visit Dates: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for Antibiotics, **OR** Hyperalimentation/Total Parenteral Nutrition?

☐ Yes ☐ No Treatment Start Date: (mm/dd/yyyy): _____ and Expected End Date: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a Surgeon's office and is the member within the 90 days post-operative period **OR** has the member started a series of surgical procedures to correct the same condition?

☐ Yes ☐ No Date of Surgery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed her first visit with an Obstetrician (OB) office?

☐ Yes ☐ No First OB Visit: (mm/dd/yyyy): _____ Expected Date of Delivery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment Start Date: (mm/dd/yyyy): _____ Last Date of Treatment: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

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.

Aetna and its affiliates comply with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna and its affiliates provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697** (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Aetna Health of California Inc. and affiliates (Aetna). Your coverage is provided by Aetna Health of California Inc.

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**.

TTY:711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน