NextLevelHealth
A healthier you. A healthier community.

Transition of Care Form

Welcome to NextLevel Health

Your health and well-being are important to us. If you or your covered dependent(s) have an unstable or serious medical condition that requires a limited course of treatment and or follow-up care and are currently being treated by an out-of-network provider, you must complete this form. The Transition of Care program will allow you to continue to receive care with an out of network provider for up to 90 days following your date of enrollment. Your care manager will help you transition your care to in-network providers during that time. To help us manage your benefits, please take a few minutes to answer the following questions:

First Name: _____ Last Name: _____ Gender: ☐ M / ☐ F

Address: _____ Apt._____ City/Town: _____ Zip code:_____

Contact telephone number(s): _____ Medical ID/RIN: _____

Please take a few minutes and review the information in this box to make sure that it is correct.

For help translating or understanding this form, please contact us at 833-ASK-NLHP (833-275-6547) TTY: Illinois Relay 711

What is the best <u>way</u> for us to reach you?

Telephone ☐ Mail ☐ Email ☐ Email address: _____

Language preference: _____

What is the best <u>time</u> to reach you? _____

Who can we contact in case of emergency?

Name: _____ Emergency contact number(s): _____

Relationship: _____

Are you currently seeing a doctor? Yes ☐ No ☐

If you are currently seeing a doctor, what are the names of the doctor(s) currently treating your condition?

Doctor's Name:	Doctor's Telephone Number:	I am seeing this doctor for:

How many times have you been to the hospital emergency room in the last three months?

☐ None ☐ Once ☐ Two or more times

If you are pregnant:

- Are you currently seeing a doctor? Yes ☐ No ☐
- Doctor's Name: _____ Phone: (___)_____
- When do you expect to deliver? _____
- At what hospital do you plan to deliver your baby? _____
- If you are not currently pregnant, did you have a baby in the last month or two? Yes ☐ No ☐

Medications:

Are you currently taking medications or using injectable medications? Yes ☐ No Do you think you will have a problem getting any prescriptions filled over the next 90 days? Yes ☐ No ☐

Medical History:

Have you been told you have any of the following? (please check all that apply)

☐ Asthma ☐ Diabetes

☐ Chronic Obstructive Pulmonary Disease ☐ Congestive Heart Failure

☐ Coronary Artery Disease ☐ Substance Abuse Needs

☐ HIV/AIDS ☐ Mental Health Needs

☐ Cancer: Type_____ Date: ____/____/_____

☐ Organ Transplant: Type_____ Date: ____/____/_____

☐ Other: _____

To help us know more about your health, please let us know if you are receiving any of these treatments or services.

	Yes	No	The name of the hospital or clinic where the service is given:
Radiation or chemotherapy			
Dialysis			
Outpatient physical, speech or occupational therapy			
Substance abuse including methadone treatment			
Counseling and/or Behavioral Health			

Additional Services:

	Yes	No		Yes	No
Home care worker or personal attendant			Visiting nurse		
Home delivered meals			Personal emergency response connected to my telephone		
Supplies delivered to your home			Day program such as Adult Day Health/Habilitation		
Were you promised in-home services, but they have not started			Other:		

Member Signature: _____ Today's Date: _____

Guardian Signature*: _____ Today's Date: _____

***If patient is younger than 18, legal guardian must sign this form.**

Thank you for helping us serve you better by answering these questions. If you want to talk with a professional from NextLevel Health right away, please call us at 833-ASK-NLHP (833-275-6547) TTY: Illinois Relay 711.

Please send this completed questionnaire to:

NextLevel Health
Attention: Transition of Care Team
224 S Michigan, Suite 700
Chicago, Illinois 60604

Or fax the completed form and any attachments to:
(312) 366-3397
Attention: Transition of Care Team

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement:

If you do not speak English, we can provide an interpreter at no cost to you by contacting NextLevel Health at: 833-ASK-NLHP (833-275-6547). If you are hearing impaired, call the Illinois Relay at 711.

NextLevel Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. NextLevel Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

NLH Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

NLH Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that NextLevel Health has 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:

NextLevel Health
Grievance Department
77 W Wacker Drive, Suite 1200
Chicago, IL 60601
Phone: 833-ASK-NLHP (833-275-6547) (TTY: 711)
Email: GA_NLH@EnvolveHealth.com
Fax:1-844-234-0701

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NextLevel Heath's Member Services Department is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-Language Interpreter Services

English- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-275-6547 (TTY: 711).

Spanish- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-275-6547 (TTY: 711).

Polish- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-833-275-6547 (TTY: 711).

Chinese- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 1-833-275-6547 (TTY：711）。

Korean- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-275-6547 (TTY: 711) 번으로 전화해 주십시오.

Tagalog- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-275-6547 (TTY: 711).

Arabic-

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-338-572-7456 (رقم هاتف الصم والبكم: 711).

Russian- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-275-6547 (телетайп: 711).

Gujarati- ध्यान द□: य□द आप □हदी बोलते ह□ तो आपके लिए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह□। 1-833-275-6547 (TTY: 711) पर कॉल कर □।

Urdu- خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں1-833-275-6547 (TTY: 711).

Vietnamese- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-275-6547 (TTY: 711).
Italian- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-833-275-6547 (TTY: 711).
Hindi- ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-833-275-6547 (TTY: 711) पर कॉल करें।
French- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-275-6547 (ATS: 711).
Greek- ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-833-275-6547 (TTY: 711).
German- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-275-6547 (TTY: 711).