



## Transitional Care Request Form

**To be completed by the MEMBER**

**Date Completed** \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Optima Member ID, if known: \_\_\_\_\_

Member Requesting Transitional Care \_\_\_\_\_

Social Security Number \_\_\_\_\_ Optima Member ID, if known: \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

Phone Numbers Home \_\_\_\_\_ Work \_\_\_\_\_

Mailing Address \_\_\_\_\_

### **Transitional Care Need**

Please briefly describe the condition for which you are requesting transitional care.

Member Signature \_\_\_\_\_

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**To be completed by PROVIDER**

**Date Completed** \_\_\_\_\_

Provider Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

Provider:

Please attach a description of the condition for which the above Optima member is requesting transitional care. Include original diagnosis date, current treatment start date and expected end date, and the medical reason(s) why care cannot be assumed by another provider. Attach additional pages, medical records, lab results or other documentation as needed.

**PROVIDER: Please return this completed form and all relevant material to**

Optima Health Plans  
Medical Care Management  
Attn: Director Medical Care Management  
4417 Corporation Lane  
Virginia Beach, VA 23462  
FAX: 757-552-7108 Phone: 757-552-8958

Thank you