KAISER PERMANENTE®

Personal and Confidential

TRANSITION OF CARE COVERAGE | REQUEST

Use this form to request coverage for a provider's services for a specific period of time. We will mail you our approval or denial. If you are enrolled in a Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. health plan and we deny coverage, then this provider's services will not be covered after the new plan's effective date.

THIS FORM MUST BE SUBMITTED TO KAISER PERMANENTE REVIEW SERVICES:

Mail: Kaiser Permanente
Review Services, RCR-A3S-05
PO Box 34589
Seattle, WA 98124

Fax: 1-844-660-0717

INSTRUCTIONS

1. Complete section 1 (patient information) and section 3 (service and provider information).
2. Sign and date section 2 (authorization). Patients 17 or older must also sign and date section 2.

For further information, contact our dedicated transition team at **206-630-0029** or **888-844-4607** (toll free), or TTY **800-833-6388** or **711**.

1. PATIENT INFORMATION

Patient name | Birthdate (MM/DD/YY) | Phone number

Kaiser Permanente Washington Member ID (optional)

2. AUTHORIZATION

Warning: Kaiser Permanente may deny plan benefits if the applicant provides false information materially related to the claim.

I am asking Kaiser Permanente (the plan) to continue covering care or equipment I have been getting from the provider named in this form. My treatment, which now includes this provider's care or equipment, began before my plan's effective date or before the plan's network terminated this provider.

I understand the coverage, if approved, will be for a limited time. By signing, I also give my permission for this provider to share my medical information or records if the plan needs them to decide whether to approve my request.

Patient's signature (required if patient is 17 or older) | Date

Parent's signature (required if patient is 16 or younger) | Date

3. SERVICE AND PROVIDER INFORMATION

To help us respond quickly, please fill in this information.

Service description | Service date(s)

Provider name or vendor | Phone number

Provider or vendor address

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