new mexico health connections

New Mexico Health Connections (NMHC)
Transition of Care Request Form

Who needs to complete this form? Newly enrolled members with NMHC who are receiving current medical treatment with a non-participating provider should complete this form and submit it to NMHC.

You also have the option to complete this form online via a secure survey: https://www.research.net/r/NMHC-TOC. NMHC uses a HIPAA-compliant platform and survey vendor to collect your personal responses.

Member Name	Member ID	Employer Name
Home Address, City, State, Zip		Employee Date of Enrollment
Home Phone/Cell Phone	Member's Date of Birth (mm/dd/yyyy)	

#	Question	Yes	No
1.	Is the member pregnant and in her second or third trimester? Due date: ___/___/_____ (mm/dd/yyyy)	☐ Yes	☐ No
2.	If yes, is the pregnancy considered high-risk? (e.g., multiple births, gestational diabetes, etc.)	☐ Yes	☐ No
3.	Is the member currently receiving treatment for an acute condition or trauma?	☐ Yes	☐ No
4.	Is the member scheduled for surgery or hospitalization after the effective date with NMHC?	☐ Yes	☐ No
5.	Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy, or terminal care?	☐ Yes	☐ No
6.	Is the member receiving treatment as a result of a recent major surgery?	☐ Yes	☐ No
7.	Is the member receiving dialysis treatments?	☐ Yes	☐ No
8.	Is the patient a candidate for an organ or bone marrow transplant?	☐ Yes	☐ No
9.	Is the member receiving behavioral health/substance abuse care?	☐ Yes	☐ No
10.	Is the member expected to be in the hospital when NMHC coverage begins or during the next 30 days?	☐ Yes	☐ No

If you did not answer "yes" to any of these questions, please describe the condition for which the member requests Transition of Care and/or list any other continuing care needs that may qualify the member for Transition of Care coverage:

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Please complete the health professional information requested below:

Group Practice Name		
Healthcare Provider Name		Provider Phone Number:
Healthcare Provider Address		
Healthcare Provider Specialty		
Hospital Where Services Will Be Rendered		Hospital Phone Number
Hospital Address		
Reason/Diagnosis		
Date of Admission (if applicable) (mm/dd/yyyy)	Date of Surgery (if applicable) (mm/dd/yyyy)	Type of Surgery
Reason for Request of Transition of Care/Treatment Being Received/Expected Duration		
I hereby authorize the above healthcare professional to give NMHC any and all of the information and medical records necessary to make an informed decision concerning my request for Transition of Care under NMHC. I understand that I am entitled to a copy of this authorization form.		
Signature of Member, Parent, or Guardian		Date (mm/dd/yyyy)

Submit request to:
New Mexico Health Connections
Attn: Case Management Department/Transitions
2440 Louisiana Blvd. NE, Suite 601
Albuquerque, NM 87110
Phone: 1-844-691-9984
OR fax to 1-866-628-3047

As this provider is neither contracted with nor has had his/her credentials verified by NMHC, we cannot ensure that the provider's background, training, and experience meet broadly accepted standards of medical practice or NMHC requirements. The purpose of the Transition of Care program is to allow you to continue receiving ongoing treatment from your existing provider for a specific medical condition for a defined time period. If at any point during the Transition of Care period, you prefer to see an NMHC-credentialed provider, please contact us for direction.