

## 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)	

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.*