StudentResources
PO Box 809025
Dallas, TX 75390
1-888-224-4754
Fax: 469-229-5632

PURDUE University: Academic year of 2022/2023 ONLY

APPLICATION TRANSITION OF CARE – applies to provider(s) who participating with the ***Anthem Network*** and **currently** seeing members, but are not a participating provider with UnitedHealthcare Choice Plus or Optum Behavioral Health Network.

Acceptance of this application is not a guarantee of benefits, payment or clinical coverage determination. Payment of services is based on your benefit plan at the time services are provided.

To complete this Application

- Please make sure all fields are completed
- The member, for whom the Transition of Care is being requested must sign the completed application. If the patient is a minor, a guardian's signature is required.
- Completed application must include the rendering/treating physician signature.
- Please upload the completed application form in your MyAccount, then select the Submit Online button. Updated forms will need to be submitted as a PDF.
- If you prefer you can mail or fax:

StudentResources
ATT: Continuity/Transition of Care
PO Box 809025
Dallas, TX 75390

Fax #: 469-229-5632

- Completion of this application does not guarantee that a Transition of Care request will be granted
- Incomplete forms will be returned to the requestor

Member Information: Completed by the applicant

☐ New UnitedHealthcare StudentResources member (Transition of Care)

Insured Name (person being treated)		**Date of Birth (mm/dd/yy)**
Address	**City**	**State / Zip Code**
SRID #:	**Email Address**	

Patients Relationship to Insured:	**Is the member currently covered by other health insurance carrier?**
☐ Self ☐ Spouse ☐ Dependent ☐ Other (need explanation):	☐ Yes ☐ No If yes, carrier name:

Authorization to release records:
I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the member's eligibility for Transition of Care Benefits under the plan.

Member's Signature / Parent or Guardian's Signature if Member is a Minor — Date (mm/dd/yy)

Signature: _____ Date: _____

StudentResources
PO Box 809025
Dallas, TX 75390
1-888-224-4754
Fax: 469-229-5632

Care Provider Section: Your health care professional should complete the follow information

☐ Please check box to confirm you previously provided care to the above member as an ***in-network Anthem Provider*** under the previous Purdue University Student Health Insurance Plan.

Physician Name:	**TIN:** **NPI:**	**Phone Number**
Physical Address:	**City**	**State / Zip Code**
Billing Name: If different than above	**TIN:** **NPI:**	
Billing Address: If different than above	**City:**	**Sate / Zip Code:**
Treating Diagnosis Code(s):		

The above-named patient is a UnitedHealthcare member. We understand you are not, or soon will not be, a participating provider in the UnitedHealthcare network. The member has asked that we allow for the next 12 months, not exceeding the current 2022/2023 policy year to process claims at the out-of-network reimbursement rate at the in-network level of benefits per their policy benefits for the covered services you provide.

Please note the following:

- The member will only be responsible for the in-network deductible, copayments and coinsurance. Provider will not balance bill the member any amount over the out-of-network reimbursement rate. UnitedHealthcare, or any payer or anyone acting on their behalf, in excess of payment in full, regardless of whether such amount is less than your billed or customary charge.
- When applicable, you will make referrals for services including laboratory services, to network providers within the UnitedHealthcare Choice Plus PPO Network.

Signature of Health Care professional

Signature: _____ Date: _____