TRANSITIONAL CARE BENEFITS

TREATMENT IN PROGRESS REQUEST FORM

Subscriber Name: _____

Subscriber ID#: _____ Employer: _____

Information regarding Member that transitional care request is for:

Member Name: _____

Member ID: _____ Phone: _____

Date of Birth: _____

Present Primary Care Physician: _____

Phone #: _____

What is the treatment in progress request for?

Diagnosis: _____

Description of present treatment:

_____

_____

_____.

Date treatment started: _____

Expected duration of treatment: _____

Treating Physician: Name: _____ Specialty: _____

Telephone number: _____

Speciality: _____

MAIL or FAX FORM BACK TO: QUALCARE Care MANAGEMENT DEPARTMENT
30 KNIGHTSBRIDGE ROAD
PISCATAWAY, NJ 08854
Phone: 1-800-254-0130 Fax: 732-562-1023

Name of person completing form: _____ Date: _____