Physicians Plus

The point of everything we do is

Medical Transition of Care

Filling out and submitting this form to Physicians Plus does not guarantee coverage of benefits and services. All services must be authorized by Physicians Plus prior to services being provided. Benefit coverage and eligibility is determined at the time of claim submission.

We want your transition to Physicians Plus to be as smooth as possible. Please fill out this form if you are currently undergoing medical treatment or pregnant and receiving services out of network. This will enable you to receive your out-of-network medical treatment during your transition period. You will also receive a notification either by mail or phone, outlining the services in network. Please contact Physicians Plus at (608) 282-8900 or (800) 545-5015 to speak with member services if you have any questions on services out of network.

Please send this form to Physicians Plus within 30 days of your new enrollment date if you, or a member of your family is undergoing medical treatment or is pregnant. Please complete one form for each family member as needed. Our provider directory can be viewed online at http://directory.pplusic.com. Our prior authorization information can be accessed online at pplusic.com/members/member-materials.

Instructions:

- Complete this form
- Fax to "Transition Form" at (608) 327-0322
- Email using the subject line "Transition Form" to ppicinfo@pplusic.com; or
- Mail to Physicians Plus, Attention: Health Services, 2650 Novation Parkway, Madison, WI 53713

MEMBER INFORMATION:	
Employer Name:	**Member ID number:**
Employee Name:	**Employee Date of Birth:**
Dependent Name:	**Dependent Date of Birth:**
Daytime Phone: **Alternative Phone:**	**Best time to contact you between 8:00 a.m. and 5:00 p.m.:**
Email Address:	

(Please see reverse for additional information)

MEDICAL INFORMATION
Current Doctor Information (Name, Address, Phone Number):
Select reason for requested transition of care request: ☐ Medical ☐ Pregnancy (Due date: _____) ☐ Mental Health ☐ Other: _____ If checked, describe condition/treatment below:

Please note: All information on this form will be kept CONFIDENTIAL, and used only for transition of medical care purposes.