Transition of Care

If you would like to research Providence network providers, you can access:

  - Search as a visitor the Connect (Medical Home) or Extend (PPO, HSA) network
- Call PHP Customer Service at 503-574-9601 or 877-574-9601
- Email Customer Service Representatives Carrie Llamas or Haley Schiager
  - carrie.llamas@providence.org
  - haley.schiager@providence.org

For more assistance navigating your transition of care to Providence Health Plan, your Transition of Care Team is here to assist!

Care Management - Non-Clinical contact
(Questions on completing the TOC form. Questions on establishing care with new providers. Providence Provider Directory search assistance. Assistance connecting with Pharmacy, Durable Medical equipment, or Diabetic supplies)
Tamby Moore - Technician-Transition of Care Team
Ph# 503.574.7957 TTY: 800-735-2900
Tamby.Moore@providence.org

Care Management - Clinical Contact
(Pregnant members, Members currently being treated for an on-going and active health condition.)
Sarah Branch, RN - Care Manager Transition of Care Team
Ph# 503.574.5819 TTY: 800-735-2900
Sarah.Branch2@providence.org

If your need assistance with your care transition, please complete the questionnaire and release of information forms and fax them to 503.574.8171 or email them to CareManagement@providence.org
Additional Transition of Care Resources

Providence Medical Equipment transitions (CPAP, BiPAP, Nebulizers, Oxygen, Respiratory equipment, Hospital beds, etc.) [https://oregon.providence.org/our-services/p/providence-home-medical-equipment/](https://oregon.providence.org/our-services/p/providence-home-medical-equipment/) Ph# 503.215.4663


Providence Pharmacy (Insulin, Questions on medication transitions, Questions on participating pharmacies, etc.) [https://healthplans.providence.org/members/pharmacy-resources/](https://healthplans.providence.org/members/pharmacy-resources/) Ph# 503.574.7400


PHP Care Management Department
Ph# 503.574.7247 TTY: 800-735-2900
[CareManagement@providence.org](mailto:CareManagement@providence.org)

Providence Health Plans Member information
[https://healthplans.providence.org/members/](https://healthplans.providence.org/members/)

Consideration of Transition of Care Request:
• Reviewed case by case.
• Decisions are based on medical necessity and not a guarantee of payment for services.
• Payment is based on eligibility and benefits at time of service.
Providence Transition of Care Questionnaire
*Please complete the questionnaire for the individual with the care transition needs*

Member Name: ___________________________ Date of Birth: ___________________________

Phone Number: ___________________________ Address: ___________________________

Member ID # (if known): ___________________________ Policy Holder Name (if dependent): ___________________________

1. What type of coverage do you have?
   □ Medicaid □ Medicare
   □ Individual Plan
   □ Through Employer (specify employer):

2. Are you a new or current member?
   □ New □ Current

3. If current, have you had a benefit change to your coverage?
   □ Yes □ No □ Unknown

4. Do you need assistance establishing care with any new providers?
   □ Yes □ No □ Unknown

5. Are any of your current providers not contracted with Providence?
   □ Yes □ No □ Unknown

   If yes, list provider, specialty and phone number:
   ___________________________
   ___________________________
   ___________________________

6. Do you have treatment scheduled prior to coming on plan?
   □ Yes □ No

   If yes, list the procedure, date, facility, provider and provider phone number:
   ___________________________
   ___________________________
   ___________________________
   ___________________________

7. Do you need assistance with any of the following?
   □ Behavioral Health □ Chemo/Radiation
   □ Substance Use □ Transplant
   □ Pregnancy □ Medical Equipment
   □ Other: __________ □ Medication

8. List provider, specialty and phone number for each condition currently being treated, current medication(s), and the type of equipment and vendor for DME supplies:

   ___________________________
   ___________________________
   ___________________________
   ___________________________
   ___________________________
   ___________________________

9. Tell us more about your situation: ___________________________

   ___________________________
   ___________________________
   ___________________________
   ___________________________

Please return the completed Transition of Care Questionnaire and Consent Form to Care Management in one of the following ways:

Mail: 3601 SW Murray Blvd.
      Beaverton, OR 97005
      Attn: Care Management

Email: CareManagement@Providence.org

Fax: 503-574-8171
AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
RELEASE BY A THIRD PARTY TO PROVIDENCE HEALTH PLAN
THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID

I authorize: ____________________________________________ (Name of provider/person/entity disclosing information) ____________________________________________ (Address) to disclose a copy of the specific health information described below regarding:

Name of Individual: __________________________ Date of Birth: __________

to Providence Health Plan (PHP) for the purpose of coordinating the transition of my care to Providence Health Plan. The specific health information to be used/disclosed consists of (Describe condition(s), treatment(s), dates of service, etc.)

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure:

____ HIV/AIDS test or result information and related records
____ Drug/alcohol diagnosis, treatment, or referral information
____ Mental health information
____ Genetic testing information

I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in Providence Health Plan or my eligibility for benefits.

I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization. Any uses or disclosures already made with my Authorization cannot be taken back.

To revoke this Authorization, please send a written statement to Providence Health Plan at P.O. Box 4327, Portland, OR 97208-4327 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this Authorization will be in force and effect until the following (check one):

Date: __________________________ - OR - Event: __________________________
at which time this Authorization to use or disclose this protected health information expires. Further, this Authorization expires 24 months from the date of signature. I have reviewed and I understand this Authorization.

By: __________________________ Date: __________
 (Individual)

- OR -

By: __________________________ Date: __________
 (Individual’s representative)
Relationship to member: Parent
Attorney

By: __________________________ Date: __________
 (Legal guardian*)

By: __________________________ Date: __________
 (Holder of Power of Attorney)

*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.