New Enrollee Non-Plan Provider Transition Policy

Applicant Name: _____

Thank you for applying to join PHP (HMO SNP), an HMO plan with a Medicare contract. Enrollment in PHP depends on contract renewal. You currently may be getting health care from providers who are not part of PHP's provider network. We call these providers "non-plan providers." PHP wants your transition to the health plan to be as convenient as possible. As a new enrollee in the plan, **you may continue to see your non-plan providers for up to 90 days from the effective date of your enrollment.**

During this 90-day period, PHP will attempt to add your non-plan providers to the PHP provider network so that you can continue to see them after the 90-day period. **If we are unable to add your non-plan providers to the network after the 90-day period, you will have to choose providers who are part of the plan's provider network.** After the 90-day period, we will tell you if you need to change providers. If you do need to change providers, a representative from our Case Management Department will contact you with in-network provider options. If you are seeing non-plan providers who you feel you must continue to see because no other providers offer comparable services, please discuss this with the Case Management Department representative. If you are getting health care from providers who are part of the PHP provider network, this policy does not apply to you.

You must use the plan's network providers to get your covered services except in limited cases such as emergency care, urgently needed care when the plan's network is not available, or out of service area dialysis. PHP lists the providers who participate with the plan in its provider directory. For more information on getting health care from the plan's provider network, please see the *Evidence of Coverage* publication.

Please list the provider(s) who you are currently seeing:

Name of Provider: _____   *Please Print*   Provider's Address: _____   *Street Address, City, State, Zip*   Provider's Telephone Number: _____

Name of Provider: _____   *Please Print*   Provider's Address: _____   *Street Address, City, State, Zip*   Provider's Telephone Number: _____

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this form means that I have read and understand the contents of this form. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this form and 2) documentation of this authority is available upon request by PHP.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____-_____

Relationship to Enrollee: _____

Office Use Only: *Check box if policy applies:* ☐
Name of Enroller: _____   Effective Date of Coverage: _____

White/**PHP**   Yellow/**Enrollee**   Y0002_2082 3 2014 110513 Approved