Martin's Point

US Family Health Plan Transition of Care Form

Your health is our top priority. To prevent coverage gaps during your transition to your Martin's Point US Family Health plan, **please complete this form or have your provider complete it for you**. The US Family Health plan will honor referrals from other TRICARE Prime providers when beneficiaries change geographical region or switch from another TRICARE PRIME Plan within the service area.

Note: Please attach any existing approved referrals or authorizations from your previous health plan to facilitate processing.

Patient Name *(last, first, middle)*: _____

Patient Date of Birth: ____/____/____ Phone Number: (____)_____

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Check all that apply:

1. Does the patient have established care with a specialist in the US Family Health Plan service area?
   ☐ Yes ☐ No
2. Is the patient currently pregnant?
   ☐ Yes ☐ No
3. If pregnant, is the pregnancy considered high-risk?
   ☐ Yes ☐ No
4. Is the patient scheduled for surgery or inpatient hospitalization?
   ☐ Yes ☐ No
5. Is the patient receiving any sort of treatment, such as physical or occupational therapy, radiation therapy, chemotherapy, or enteral nutrition therapy?
   ☐ Yes ☐ No
6. Is the patient receiving mental health or substance abuse care?
   ☐ Yes ☐ No
7. Is the patient currently renting durable medical equipment from a provider (ex., oxygen, CPAP, insulin pump, continuous glucose monitor (CGM), ostomy or catheter supplies)?
   ☐ Yes ☐ No

Please provide the name, address, and phone number for any specialist from which you are currently receiving care in the US Family Health Plan's service area or via telehealth.

Provider #1 Hospitalization/Procedure/Appointment Date: _____/_____/_____

Date you began seeing this provider for this course of treatment: _____/_____/_____

ProviderName: _____

Provider Address: _____

Provider Phone #: _____

Provider Fax #: _____

Reason for Visit: _____

Is provider out of network? ☐ Yes ☐ No ☐ Unsure

Provider #2 Hospitalization/Procedure/Appointment Date: _____/_____/_____

Date you began seeing this provider for this course of treatment: _____/_____/_____

Provider Name: _____

Provider Address: _____

Provider Phone #: _____

Reason for Visit: _____

Is provider out of network? ☐ Yes ☐ No ☐ Unsure

Patient or Guardian's Signature _____

Returning Your Form

Please use the enclosed envelope to return this form by mail to:
Health Management Department, Martin's Point Health Care, PO Box 9746, Portland, ME 04104

Have questions? Need help completing this form?

Please call the Member Services number on the back of your member ID card.