True Health New Mexico
Transition of Care Request Form

Newly enrolled members with True Health New Mexico who are receiving current medical treatment with a non-participating provider should complete this form and submit it to True Health New Mexico. You may also complete this form online via a secure survey: https://www.research.net/r/THNM-TOC. True Health New Mexico uses a HIPAA-compliant platform and survey vendor to collect your responses.

Member Name	Subscriber ID	Employer Name
Home Address, City, State, Zip		Employee Date of Enrollment
Home Phone/Cell Phone	Member's Date of Birth (mm/dd/yyyy)	

1. Is the member pregnant and in her second or third trimester? Due date: ___/___/_____ (mm/dd/yyyy) ☐ Yes ☐ No
2. If yes, is the pregnancy considered high-risk? (e.g., multiple births, gestational diabetes, etc.) ☐ Yes ☐ No
3. Is the member currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No
4. Is the member scheduled for surgery or hospitalization after the effective date with True Health New Mexico? ☐ Yes ☐ No
5. Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy, or terminal care? ☐ Yes ☐ No
6. Is the member receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
7. Is the member receiving dialysis treatments? ☐ Yes ☐ No
8. Is the patient a candidate for an organ or bone marrow transplant? ☐ Yes ☐ No
9. Is the member receiving behavioral health/substance abuse care? ☐ Yes ☐ No
10. Is the member expected to be in the hospital when True Health New Mexico coverage begins or during the next 30 days? ☐ Yes ☐ No

If you did not answer "yes" to any of these questions, please describe the condition for which the member requests Transition of Care and/or list any other continuing care needs that may qualify the member for Transition of Care coverage:

_____

_____

Please complete the health professional information requested below:

Group Practice Name		
Healthcare Provider Name		Provider Phone Number:
Healthcare Provider Address		
Healthcare Provider Specialty		
Facility/Hospital Where Services Will Be Rendered		Facility/Hospital Phone No.
Facility/Hospital Address		
Reason/Diagnosis		
Date of Appointment (if applicable) (mm/dd/yyyy)	Date of Surgery (if applicable) (mm/dd/yyyy)	Type of Surgery
Reason for Request of Transition of Care/Treatment Being Received/Expected Duration		
I hereby authorize the above healthcare professional to give True Health New Mexico any and all of the information and medical records necessary to make an informed decision concerning my request for Transition of Care under True Health New Mexico. I understand that I am entitled to a copy of this authorization form.		
Signature of Member, Parent, or Guardian		Date (mm/dd/yyyy)

Submit request to:
True Health New Mexico, Attn: Case Management Department/Transitions
2440 Louisiana Blvd. NE, Suite 601, Albuquerque, NM 87110
Phone: 1-844-691-9984 – **OR fax to 1-800-725-1582**

As this provider is neither contracted with nor has had his/her credentials verified by True Health New Mexico, we cannot ensure that the provider's background, training, and experience meet broadly accepted standards of medical practice or True Health New Mexico requirements. The purpose of the Transition of Care program is to allow you to continue receiving ongoing treatment from your existing provider for a specific medical condition for a defined time period. If at any point during the Transition of Care period, you prefer to see a True Health New Mexico-credentialed provider, please contact us for direction.