Exhibit A

Transition of Care/Continuity of Care request form

See instructions for completing this form on the reverse side.

o New Integra Harmony enrollee (Transition of Care applicant)

o Existing Integra Harmony Member whose health care provider terminated (Continuity of Care applicant)

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employer	Policy #	Employee Date of Enrollment in Plan (mm/dd/yyyy)

Employee Name	Employee Member ID	Work Phone

Home Address	Street	City	State	ZIP	Home Phone/Mobile

Patient's Name	Patient's Social Security # or Alternate ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee o Spouse o Dependent o Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? Due Date _____________(mm/dd/yyyy) o Yes o No
2. If yes, is the pregnancy considered high risk? e.g., multiple births, gestational diabetes. o Yes o No
3. Is the patient currently receiving treatment for an acute condition or trauma? o Yes o No
4. Is the patient scheduled for surgery or hospitalization after your effective date with Integra? o Yes o No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? o Yes o No
6. Is the patient receiving treatment because of a recent major surgery? o Yes o No
7. Is the patient receiving dialysis treatment? o Yes o No
8. Is the patient a candidate for an organ transplant? o Yes o No
9. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care/Continuity of Care.

____

10. Please complete the health care provider information requested below.

Group Practice Name	
Health Care Provider Name	Health Care Provider Phone #
Health Care Provider Specialty	
Health Care Provider Address	
Hospital Where Health Care Provider Practices	Hospital Phone #
Hospital Address	
Reason/Diagnosis	

Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery

Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when coverage through Integra Harmony begins or during the next 90 days? o Yes o No

12. Please list any other continuing care needs that may qualify for Transition of Care/Continuity of Care. If these care needs are not associated with the condition for which you are applying for Transition of Care/Continuity of Care, you need to complete a separate Transition of Care/Continuity of Care request form.

I hereby authorize the above health care provider to give Integra Harmony and contracted parties any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Submit this request form to:

Integra Harmony Health Plan
Attention: Care Management
3200 Park Lane Drive, Lake Success, NY #####
Fax: **General Medicare Fax:** 516-321-4638

Transition of Care/Continuity of Care requests will be reviewed within 10 days of receipt. For new Integra Harmony customers, review will occur within 10 days of participant's effective date. Review for organ transplant requests may take longer than 10 days.

Instructions for completing the Transition of Care/Continuity of Care request form

Note: A separate Transition of Care/Continuity of Care request form must be completed for each condition for which you and/or your covered dependents are seeking Transition of Care/Continuity of Care. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Transition of Care/Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.

To help ensure a timely review of your request, please return the form as soon as possible. You must apply for Transition of Care/Continuity of Care within 30 days of the effective date of your plan, or within 30 days of your provider's termination date.

The first few sections of the form apply to the employee. When the form asks for the patient's name, enter the name of the person who is receiving care and is requesting Transition of Care/Continuity of Care.

If you answered yes to questions #1, #2, #3, #4, #5, #6, #7 or #8, please submit this request form to:

Integra Harmony Health Plan
Attention: Care Management
Address: 1981 Marcus Ave, Suite 100
Lake Success, NY 11042
Fax: **General Medicare Fax:** 516-321-4638

In #9, include information about the current or proposed treatment plan and the length of time treatment is expected to continue. If surgery has been planned, state the type and the proposed date of the surgery.

In #12, briefly state the health condition, when it began, what health care provider is currently involved, and how often you see this health care provider. Please be as specific as possible.

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