



## APPLICATION FOR TRANSITION OF CARE

**Physician:**

Please fill out and check the entire form for completeness before submission to UnitedHealthcare.

SECTION 3 TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION		
Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	Is treatment for an exacerbation of a previous injury or chronic condition? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Current Treatment/Comments		
Signature of Physician		Date
SECTION 4 FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE		
Care Coordination Representative's Name	Transition of Care: <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved (please document reason below)	
Comments		
Care Coordination Representative's Signature		Date: