TRANSITION OF SERVICE FORM FOR
MIAMI-DADE COUNTY/JACKSON HEALTH SYSTEM
NON-CURRENT AVMED MEMBERS ONLY

Mail to: AvMed On Call, P.O. Box 569004, Miami, FL 33256-9942
Fax to: 1-800-552-8633

AvMed
SELF-FUNDED OPTIONS

If you are enrolling with AvMed Health Plans and require assistance with transition of your medical service from your current health plan and their providers, please complete this form and fax it or mail it in. This information will NOT be used in any way to affect your eligibility – this form is only to assist us in arranging a smooth transition of your medical care to AvMed providers. In certain circumstances, you may be able to continue treatment with your current physician. To assure coverage, any planned or on-going treatment must be coordinated and approved by AvMed prior to services being rendered. *Please complete this form for each person in your family that requires Transition of Service.*

Employer Group: _____ **Employee/Retiree:** _____

Employee SS#: _____ **Current Health Plan:** _____

Member Information

Member Last Name:	First:	MI:	Date of Birth:
Address (Street):	City:	State:	Zip Code:

Work Phone #:	Home Phone #:	Today's Date:	Social Security #:
Relationship to Employee: Self – Spouse – Child – Other	Current Primary Care or Treating Physician:		Physician Phone #:

I. Ongoing Medical Treatment:

Current Active Chemotherapy / Radiation: Y / N
Previous Chemotherapy / Radiation: Y / N
Dialysis: Y / N – Facility _____
Transplant: Y / N – When _____ Type _____
Transplant Pending: Y / N – Provider Name _____
Scheduled Surgical Procedure (within 90 days): Y/N
Other: Y / N (Please Describe): _____

Heart Failure: Y/N
Asthma: Y / N
Diabetes: Y / N
Open Wound: Y / N
Behavioral Health: Y / N
Enrolled in current health plan's Case Management Program: Y / N

II. Are you pregnant? Y/N. High risk pregnancy? Y/N

Due Date:	Obstetrician:	Physician Phone #:	Hospital you plan to deliver at:

Any complications during your pregnancy? Y / N If yes, please specify (examples: high blood pressure, thyroid problems, diabetes):

III. Chronic Care: List current prescription medications including injectables: (We can tell you which medications may require a special authorization)

_____

_____

If you are on Insulin, do you use more than 3 vials (30ml) for all of your injections combined in one month? Y/N

Do you have an ACCU-Chek Glucometer? Y / N. If so, what type? Do you use more than 204 test strips/month? Y / N

IV. Current Medical Services (So we may assist the transition to your new group coverage)

Home Care: Y / N. If yes, name of agency: _____ Phone #: _____ For what reason? (therapy, nursing, IV, wound care, etc): _____. Are you currently being treated at any wound care center or hyperbaric oxygen center? Y / N. Current durable medical equipment: Y / N. If yes, type: CPAP Oxygen, Hospital, Bed, Other (please list): _____
Name of Vendor: _____ Phone #: _____

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider, as well as Current Health Plan named above, to release for review my or my enrolled dependent child's (under age 18) medical records to AvMed Health Plans. This authorization includes psychiatric and substance abuse records and concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children (if covered by your policy) for treatment, payment and health care operations.

_____ _____
Member Signature (REQUIRED) Date (REQUIRED)

If the Nurse On Call has not contacted you within 30 days of submission of form, please call 1-888-866-5432.