Transition of Care Questionnaire

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed. Please send the completed questionnaire to TieCare International:

- **Email:** customerservice@tiecare.com
- **Fax**: +1.949.271.2330

A. POLICYHOLDER INFORMATION	
Name (Last, First, MI):	
Policy #:	Member ID #:
Employer (if applicable):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	

B. APPLICANT INFORMATION (Complete if spouse/dependent. Relationship to Policyholder: ☐ Spouse ☐ Dependent)	
Name (Last, First, MI):	
Date of Birth (DD/MMM/YYYY):	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	

C. TRANSITION OF CARE QUESTIONNAIRE		
Is the patient pregnant and in the second or third trimester of pregnancy? If yes, due date (DD/MMM/YYYY): ____________________ Is the pregnancy considered high risk? (Multiple births, gestational diabetes, etc.) If yes, please explain: ____.	☐ Yes	☐ No
Is the patient currently receiving treatment for an acute condition or trauma?	☐ Yes	☐ No
Is the patient scheduled for surgery or hospitalization after your effective date?	☐ Yes	☐ No
Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care?	☐ Yes	☐ No
Is the patient receiving treatment as a result of a recent major surgery?	☐ Yes	☐ No
Is the patient receiving dialysis treatment?	☐ Yes	☐ No
Is the patient a candidate for organ transplant?	☐ Yes	☐ No
Is the patient receiving mental health/substance abuse treatment?	☐ Yes	☐ No

TieCare is the marketing name for TieCare International, LLC. Administration and intermediary services for the insurance coverage are provided by or through operating affiliates of TieCare International, LLC, including Total Scholastic Solutions, LLC, TSS Assist, Inc., TSS Administrative Services, Inc., and TSS Underwriting, LLC. Insurance coverage is provided by an insurance company unaffiliated with TieCare.

If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care:	
Diagnosis:	
Treatment being received and expected duration:	
Is this patient expected to be in the hospital when coverage with TieCare begins or during the next 90 days? If yes, please explain.	
List any other continuing care needs that may qualify for Transition of Care coverage. If these needs are not accompanying the condition for which you are applying for Transition of Care coverage, you need to complete a separate Transition of Care form.	

D. DOCTOR/FACILITY INFORMATION

Applicant's Doctor/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:
Name and address of doctor(s)/hospital(s) from which the treatment was received:	
If treatment was given in hospital as an inpatient please provide the dates (DD/MMM/YYYY):	
Date(s) of Surgery (DD/MMM/YYYY), if applicable:	Type of Surgery:
Was the Insured Person pregnant: ☐ Yes If yes, how many weeks? ________________. ☐ No	
If the Insured Person suffered an illness, has he/she suffered from this before: ☐ Yes ☐ No If yes, please provide details:	

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FOR EU CITIZENS ONLY: Was a European Health Insurance Card (EHIC) taken on this trip? ☐ Yes ☐ No	
If yes, was the EHIC presented to the hospital or physician? ☐ Yes ☐ No If no, please explain:	

E. AUTHORIZATION / DECLARATION

A. AUTHORIZATION

I hereby authorize any physician or other healthcare professional, hospital or healthcare-related facility, pharmacy, medical service provider, employer, benefit plan administrator, and any Federal, State or Local Government Agency, with a complete copy of any and all medical information for use and disclosure as described in this authorization. Further to release any medical and other information in your possession or control to TieCare International and/or their attorneys, either directly or through a representative agent acting on their behalf, any and all medical information they may request, including but not limited to, medical records, reports, charts, graphs, x-ray notes, films, and laboratory reports.

I also hereby authorize the release of all medical information regarding diagnosis, care and treatment for alcohol abuse, drug abuse or mental health. In addition, I authorize the release of any and all billing records and statements in your possession or control.

I also authorize TieCare, its representatives or their agents to release information that is obtained pursuant to this authorization to providers of healthcare, insurers, reinsurers, or claims administrators, and any government agency as it deems appropriate solely for the purpose of evaluating and administering any claim for benefits. I further understand that information may be released as follows: To other persons or organizations performing business or legal services in connection with any claim; As may be otherwise lawfully required; To any person or legally authorized representative as I have so indicated; As I may further authorize; or as necessary to prevent or detect the perpetration of fraud.

This "Authorization For Release of Medical Information" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. I know that I may request to receive a copy of this Authorization.

B. DECLARATION

I consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.
I declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and we will exercise these rights where applicable.
I declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

Name:	Date:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	

Privacy Notice
The TieCare International group of companies includes brokering and management companies, as well as assistance and administration companies. We respect your privacy, and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at www.totalscholasticsolutions.com/privacy-policy and we would advise you to read the policy so you understand your rights and your personal data use by the TSS Group.