Northern Light℠
Beacon Health
Employee Health Plan

New Member Transition of Care Form

We're here to help! Our Customer Service Professionals will work with you and your providers so you can access medically necessary services. For example: medication infusions, scheduled surgery.

Welcome to our Northern Light Employee Health Plan! As your self-funded medical plan, we'll work hard to ensure you receive the care you need to lead a healthy life. Our priority is supporting your access to high quality, coordinated and seamless care. Please provide us with the following information:

First and last name _____ Date of Birth _____

Phone _____ Email address _____

Member ID number (if received) _____ Name of NLH Member Organization _____

If you are being treated by a provider that is not in our Northern Light or Beacon Health Network, please allow us to assist you with your transition to our Plan Network. To see if your provider is in the Beacon Health Network, go to **EmployeeHealthPlan.NorthernLightHealth.org** website and look under the member tab to search for your provider.

If any of the situations below apply to you or your dependents covered under our medical plan, please complete this form, sharing all the information requested.

To be eligible for consideration, you or your family member must:

- Be receiving ongoing care for specific medical conditions* (See Question 1 for typical conditions)
- The care must have started prior to enrollment with the Northern Light Health Employee Health Plan.

To request New Member Transition of Care, please answer the following questions:

1. What are you requesting Transition of Care for? If not listed, please explain.

☐ Pregnancy	☐ Behavioral health condition	☐ Specialty Pharmacy/home infusion
☐ Cancer: newly diagnosed/ongoing cancer treatment	☐ Enrollment in a care management/ disease management program	☐ Recent heart attack
☐ Sick newborn requiring intensive care	☐ Acute trauma or surgery	☐ Pharmacy
☐ Scheduled or approved elective surgery	☐ Applied Behavioral Treatment (ABT)	☐ Rare medical condition or other (please specify below)
☐ Durable medical equipment in my home (Ex: oxygen, CPAP, BiPAP, hospital bed, nebulizer machine, etc.)	☐ Physical therapy, occupational therapy, or speech therapy	☐ Nursing home and receiving skilled care

Other: _____

2. What is the name of the provider(s) you or your dependent receive care from?

   Provider name _____ Phone _____ Provider address _____

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3. When was the last time you or your dependent saw this provider(s) for the conditions noted?

   _____

4. How often do you or your dependent see this provider(s)?

   _____

5. What's the best way to reach you during business hours? ☐ Email ☐ Telephone
   Do you give us permission to leave a message? ☐ Yes ☐ No

6. Information you wish to share:

   _____

Please return this completed form by email to: **beaconmemberserv@northernlight.org**
A member of our Medical Management team will contact you to discuss your needs and help you make a smooth transition to our Northern Light Employee Health Plan. If you have questions, call our Medical Management team; Weekdays 8am – 5pm at 855-429-1024

_____ _____
Member signature (Parent or legal guardian for members under age 18) Date