Transitioning Your Care to KelseyCare Advantage: What You Need to Know

Thank you for choosing KelseyCare Advantage Medicare Health Maintenance Organization!

KelseyCare Advantage Medicare Health Maintenance Organization (MA HMO) wants to make your transition to our plan as smooth as possible. During your first 30 days of membership, you can apply for Transition of Care to have your current physician continue your treatment for a little while longer. However, you may be required to begin getting services from network providers immediately.

Please call KelseyCare Advantage Member Services with any questions you might have about transitioning your care to KelseyCare Advantage MA HMO.

(713) 442-2ERS (2377) or (877) 853-9075
TTY/TDD: (866) 302-9336
8 a.m. to 5 p.m., Monday-Friday

In particular, please call us if any of the following situations apply to you:

- You have had surgery in the last 90 days.
- You are currently undergoing chemotherapy or radiation treatment.
- You are having physical therapy.
- You are receiving home health services.
- You have durable medical equipment, such as a wheelchair, oxygen tank, or home bed.

In these cases, we recommend that you:

Submit a "Transition of Care Request Form" online by visiting www.kelseycareadvantage.com/ers.

Call KelseyCare Advantage Member Services at the phone number above.

Services that generally do not qualify for transition of care include, but are not limited to:

- Routine exams, vaccinations and health assessments
- Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension, and glaucoma
- Acute minor illnesses such as colds, sore throats, and ear infections
- Elective scheduled surgeries

What's next?

Once you have submitted a Transition of Care Request Form or called Member Services, your situation will be reviewed by a nurse.

Within fourteen business days, we will mail you either an approval or denial letter informing you of the outcome of your transition of care request.

ERS
Employees Retirement System of Texas

KelseyCare Advantage

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Return this form to:
KelseyCare Advantage
11511 Shadow Creek Parkway
Pearland, TX 77584
Fax: 713-442-5450

Transition of Care Request Form

Member Information

First Name: _____ Middle Initial:_____ Last Name:_____

Member ID Number: _____ Date of Birth:____/____/_____Effective Date:____/____/_____

Type of Request:

__ Radiation/Chemotherapy ___ Surgery ___ Physical Therapy

__ Durable Medical Equipment ___ Home Health

__ Other- Please specify: _____

What services from non-network providers do you believe you need to continue receiving?

_____

_____

Please list the contact information of the providers you are using:

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

I hereby authorize the above provider(s) to give KelseyCare Advantage any and all information and medical records necessary to make an informed decision concerning my request for transition of care under KelseyCare Advantage. I understand I am entitled to a copy of this authorization form.

Signature of Patient: _____ Date (mm/dd/yyyy) _____

Signature of Guardian (if applicable): _____ Date (mm/dd/yyyy) _____