moda HEALTH

Transition of Care Request ☐
Member transitioning on to new plan

Continuity of Care Request ☐
Provider terming from network

Patient name	Date of birth (mm/dd/yyyy)	ID no.	Patient phone
Provider/Physician		Contact Name	Provider/Physician phone
Facility (if applicable)		Contact Name	Facility phone
Diagnosis	Service/Procedure(s)		If pregnant, due date
Requested Date Span			

Please include a brief clinical summary of patient's condition and treatment plan below. To be completed by Attending Physician.

Provider Signature _____

Ready to submit? Fax request form and supporting clinical documentation to 503-243-5105, or secure email to transitionofcare@modahealth.com

Questions? Contact Moda Health at 888-393-2940.

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