JOHNS HOPKINS
HEALTH PLANS

Transition to Plan Form

Please complete this form if you or a dependent have any health care services scheduled, are renting any durable medical equipment or are managing a complex condition. Our staff will make sure you have the authorizations and support you need while you transition to the plan. Johns Hopkins US Family Health Plan allows new members to see an out-of-network provider if the wait time for an in-network provider is longer than four weeks.

Please provide this information for the member or dependent needing care, if not yourself.

Beneficiary Information

First Name:	Last Name:
Date of Birth:	Home Address:
Home Phone:	
Cell Phone:	State, City, ZIP Code:

Current Care

	Yes	No
1. Are you currently seeing an out-of-network provider within the USFHP service area?	☐	☐
2. Are you scheduled for surgery or inpatient hospitalization?	☐	☐
• If yes, provide date of service: _____________________________		
• Are you currently receiving any ongoing treatments (such as physical or occupational therapy, radiation, chemotherapy or enteral nutrition)?	☐	☐
• Are you receiving mental health care or substance use care?	☐	☐
• Are you currently enrolled in ECHO/ABA?	☐	☐
• Are you currently renting durable medical equipment (such as oxygen, CPAP, insulin pump, CGM)?	☐	☐
3. Would you like support managing your health or coordinating your care? If yes, complete questions below.	☐	☐
• Do you have a chronic health condition like diabetes, hypertension or COPD?	☐	☐
• Do you have a high-risk pregnancy?	☐	☐
• Do you want help with advance care planning?	☐	☐

If you indicated **Yes** to any of the above questions, please complete the Provider Information on the following page.

Provider Information

	Provider 1	Provider 2
Hospitalization/Procedure/ Appointment Date	_____/_____/_____	_____/_____/_____
Date treatment began with this provider	_____/_____/_____	_____/_____/_____
Provider Name	______________________________	______________________________
Provider Address	______________________________	______________________________
	______________________________	______________________________
Provider Phone No.	______________________________	______________________________
Provider Fax No.	______________________________	______________________________
Reason for visit	______________________________	______________________________
Out of network?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

	Provider 3	Provider 4
Hospitalization/Procedure/ Appointment Date	_____/_____/_____	_____/_____/_____
Date treatment began with this provider	_____/_____/_____	_____/_____/_____
Provider Name	______________________________	______________________________
Provider Address	______________________________	______________________________
Provider Phone No.	______________________________	______________________________
Provider Fax No.	______________________________	______________________________
Reason for visit	______________________________	______________________________
Out of network?	☐ Yes ☐ No ☐ Unsure	☐ Yes ☐ No ☐ Unsure

Member or Guardian's Signature ______________________________________ Date_____/_____/_____

By signing this form, I attest that the information provided above is true, complete and accurate to the best of my knowledge. I understand that providing false, incomplete or misleading information may affect my coverage or care coordination.

You may email this form directly to clerkscsremails@jhhp.org.