HAP CareSource™

PHYSICIAN-INITIATED MEMBER TRANSFER REQUEST

SECTION 1: TO BE COMPLETED BY HAP CARESOURCE™ PRIMARY CARE PHYSICIAN

Primary Care Physician _____ NPI _____

Office Address _____

_____

Phone _____ Fax _____

Email _____

Member Name _____ HAP CareSource ID # _____

Please document in section 1A on the reverse side, the reasons you believe this HAP CareSource member should be transferred from your care and the steps you have taken to reconcile the relationship. Use specific references to behaviors or activities you consider to be non-compliant. Include dates of all occurrences, previous attempts to improve the relationship and communication you've had with the member indicating persistent, non-compliance would lead to termination of the physician-patient relationship. **Attach additional documentation as necessary, including any correspondence with the member. Failure to include any of these examples will result in the denial of this termination request.**

After completing sections 1 and 1A, sign and date this form below and send it to your HAP CareSource network group medical director or their designees. **Please do not send form directly to HAP CareSource**.

I understand that I will continue to provide care for this HAP CareSource member pending the final decision of this transfer request and until any such transfer is effective.

Signature of Primary Care Physician **Date**

SECTION 1A: SEE REVERSE SIDE

SECTION 2: TO BE COMPLETED BY HAP CARESOURCE NETWORK GROUP MEDICAL DIRECTOR OR THEIR DESIGNEE

Please review sections 1, 1A and any additional enclosed documentation and indicate an action below.

	Transfer member to another PCP within this network
	Transfer member to another HAP network (reasons why care should not continue within your network should be indicated below). Please refer to HAP CareSource policy C_Corporate_Provider Serivces_001 for network transfer requirements.
	Transfer denied **(include supporting documentation)**

Network/Group Medical Director or Designees Comments:

_____

_____

Signature of Network/Group Medical Director or Designees **Date**

Send the completed form and all documents by mail or fax:

Mail: HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1025
Dayton, OH 45401

Fax: 937-396-3492

OVER

SECTION 1A – TO BE COMPLETED BY HAP CARESOURCE PRIMARY CARE PHYSICIAN

Documentation in support of member transfer request:

Date of Occurrence	Description of Occurrence

Date(s) of Contact	Description of Attempted Resolution

This information is also documented in the patient's medical record(s): **YES** **NO**

If no, please provide explanation. Attach additional documentation as necessary.