MEDICAL MUTUAL®

Transition of Care - Waiver Request

Instructions: Please complete a separate form for each person for whom a transitional care waiver is being requested.

Policyholder name: _____ **Certificate number**: _____

Group name: _____ Group number: _____

Patient Information (*for whom transitional care waiver is requested*)

Name: _____ Date of birth: _____ Sex: ☐ Male ☐ Female

Phone number: _____ Street address: _____

City: _____ State: _____ ZIP: _____

Relationship to policyholder: ☐ Self ☐ Spouse ☐ Dependent

1. Name of physician/hospital/provider: _____ Specialty:_____

Phone number: _____ Street address: _____

City: _____ State: _____ ZIP: _____

Medical reason for which a transitional care waiver is requested:

Attach any additional medical documentation that supports your request.

2. Name of physician/hospital/provider: _____ Specialty:_____

Phone number: _____ Street address: _____

City: _____ State: _____ ZIP: _____

Medical reason for which transitional care waiver is requested:

Attach any additional medical documentation that supports your request.

Type of surgical procedure (If applicable): _____

Date of planned surgery/delivery (If applicable): _____ Hospital: _____

Send request for a transitional care waiver to:

Care Authorizations
MZ: 01-5B-3982
Medical Mutual
2060 East Ninth Street
Cleveland, OH 44115-1355

Fax: (877) 321-6664