MEDICAL MUTUAL OF OHIO®
And Its Family of Companies

OhioMed™

STATE OF OHIO
TRANSITION of CARE WAIVER REQUEST

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

Policy Holder 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: _____ Address: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Dependent

1. Name of physician/hospital/provider_____ Specialty_____

Address_____City/State_____Phone_____

Medical reason a transitional care waiver is requested_____

_____

_____

_____

Attach any additional medical documentation that supports your request.

2. Name of physician/hospital/provider_____ Specialty_____

Address_____City/State_____Phone_____

Medical reason a 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:

Utilization Management
MZ: 01-5B-3981
2060 East 9th Street
Cleveland, OH 44101

Fax: 1.800.517.2583

Revised: 10/30/2009