Transition of Care
Waiver Request

Contracting providers must submit requests through Cohere.

General Information	
Policyholder Name	Certificate Number
Group Name	Group Number

Patient Information (for whom transitional care waiver is requested)

Name				
Date of Birth	Sex Male Female	Relationship to Policyholder Self Spouse Dependent		
Street Address				
City			State	ZIP

Provider Information

Provider 1			
Name of Provider/Physician/Hospital			
Specialty		Phone	
Street Address			
City		State	ZIP
Medical reason for which a transitional care waiver is requested*			

Provider 2			
Name of Provider/Physician/Hospital			
Specialty		Phone	
Street Address			
City		State	ZIP
Medical reason for which a transitional care waiver is requested*			

Type of surgical procedure (if applicable)	Planned Date
Hospital	

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L9260-PRV R2.24

*Please attach any additional medical documentation that supports your request.

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Non-contracting providers, please send completed form to:

Mail
Medical Mutual Prior Authorizations
MZ: 02-3P-7516
100 American Road
Cleveland, OH 44144

Fax
1-877-321-6664