

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 MM/DD/YYYY	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 MM/DD/YYYY	
Hospital			

*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