caron
Transformational Care

Lucent Health
Repricing by PERMA FAIR

Transition Made Easy

Continuing Your Care Without Disruption

Welcome to your new health plan! We want this transition to feel easy and supported—especially if you're receiving complex or ongoing care, like cancer treatments, infusions, home health services, or have a surgery scheduled within 30 days of your plan's start date.

Our team is here to help coordinate your care and make sure your providers have everything they need for a smooth transition.

Coordinate with your provider

Let your doctor know you're moving to a new health plan. We'll work with them directly if any updates or prior steps are needed.

*Tip: Refill prescriptions and medical supplies ahead of time to help ensure a smooth transition.

Complete your Transition to Plan Questionnaire & Medical Release

Fill out your forms so we have the information needed to support your ongoing care.

Return Your Forms to the Member Experience Advocate Team

Email: help@permafair.com
Fax: (856)291-5300
Questions: Call (877) 428-1286

Continue Your Care

We'll contact your provider to share any needed information and help keep your treatment moving without disruption, in-network or out-of-network.

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NEW MEMBER TRANSITION TO PLAN QUESTIONNAIRE

We are here to help as you transition to your new health plan! If you have questions regarding your provider(s), we can offer you help. To help us obtain information to support your transition, please complete the below form regarding your request and return it to us by email at help@permafair.com or by fax at 856-291-5300.

MEMBER INFORMATION:

Date:					
Employee Name:					
Home Address:		City, State:		Zip Code:	
Employee Phone:		Employee Email:			
Patient Name:		Patient DOB:		Relationship to Employee:	
Patient Phone:		Patient Email:		Best Time to Call:	

- What is your preferred method to contact you during business hours? ☐ Email ☐ Telephone
- Do you give us permission to leave a message? ☐ Yes ☐ No

How Can We Help You?

PROVIDER INFORMATION:

Provider #1 Name:	Next Appointment Date:	Reason for Next Appointment:
Provider Address:	Provider Phone Number:	
Diagnosis/Treatment:		
Comments:		
Provider #2 Name:	Next Appointment Date:	Reason for Next Appointment:
Provider Address:	Provider Phone Number:	
Diagnosis/Treatment:		

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Comments:		
Provider #3 Name:	Next Appointment Date:	Reason for Next Appointment:
Provider Address:	Provider Phone Number:	
Diagnosis/Treatment:		
Comments:		
Provider #4 Name:	Next Appointment Date:	Reason for Next Appointment:
Provider Address:	Provider Phone Number:	
Diagnosis/Treatment:		
Comments:		

QUESTIONNAIRE COMPLETED BY (ONLY COMPLETE IF FORM NOT COMPLETED BY PATIENT):

Name of Person Completing Questionnaire:	
Date:	
Relationship to Patient:	
Phone:	
Email:	

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MEDICAL RELEASE FORM

This form allows your health plan to access information regarding your medical history to effectively assist in coordination of your care. If you have any questions, please don't hesitate to contact us at 1-877-428-1286.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ / ____ / ____

Address: _____

City/State/ZIP: _____

Phone Number: _____

Email Address: _____

AUTHORIZED HEALTHCARE PROVIDER

I authorize the following healthcare provider to release my health information:

Provider Name: _____

Address: _____

Phone: _____ Fax: _____

MEDICAL RELEASE

I hereby give my authorization for the release both verbally and in writing, of my medical records, to PERM FAIR, TPA and BillingNav LLC to include treatment diagnoses, diagnostic records, laboratory results, and other information in my health record to the health plan to utilize for care coordination and claims processes. This release is effective for one year following the date of my signature and applies to all current treating healthcare providers. I understand that I may revoke this authorization at any time by submitting a written request to the provider, except to the extent That action has already been taken. Make documents generic, not TPA specific (addressed in my request below)

Name of Patient/Guardian: _____ Date: _____

Signature of Patient/Guardian: _____ Date: _____

Please return completed Questionnaire along with this Medical Release form by:

Email: help@permafair.com Fax: 856-291-5300

With respect to the HIPAA Privacy Rule, a permissible use or disclosure of Protected Health Information is for Treatment, Payment, or Healthcare Operations per section 164.502(a)(1)(ii). This request is being made by the health plan and its Business Associate for determining eligibility and coverage under the plan, reviewing heath care services for medical necessity, coverage, justification of charges, and the like; and utilization review activities which are defined as Payment per section 164.501 of the Privacy Rule.

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