DeanHealthPlan
A member of SSM Health

1277 Deming Way
Madison, WI 53717
phone: 800-279-1301
Medicare: 888-422-3326
TTY: 711
deancare.com

Transition of Care Request Form

Please complete, sign and return this form as soon as possible to Dean Health Plan:

Fax
(608) 252-0879

Email
DHP.TraCareFormBox@deancare.com

Mail
Dean Health Plan
PO Box 56099
Madison WI 53705

Employer Name:			
Employee Name:			
Enrollment Date:	*Plan Type : [ ]HMO [ ] PPO [ ]POS [ ] Other _____*		
Patient Name:		*Patient Birth Date:*	
Relationship to Patient:		*Primary Phone:*	
Patient Address:		*Work Phone:*	
		May we contact you at work? [ ]Y [ ]N	*Best Time to Reach You: [ ]morning [ ]day [ ]evening*
Description of condition and treatment in progress:			

Current Providers	*Provider 1*	*Provider 2*	*Provider 3*
Provider name:			
Location:			
Phone:			
Specialty:			
Last visit:			
Next visit:			

****Diagnostic Services (i.e. labs and x-rays) that are available in network must be provided with plan providers.****

By signing below, you consent to having a DHP representative contact you or your dependent, if applicable, regarding transition of care questions. If the care described above is for your **spouse or dependent over age 18**, a representative will contact your spouse or dependent.

Signature of policy holder **Date** **Phone number**

Spouse/Dependent's Name **Date** **Phone Number**