



Pre-existing Conditions/Continuation of Care Procedures Prior to Departure

Participants with pre-existing conditions who will need continuation of care while abroad are encouraged to open a case with Team Assist prior to departure. Continuation of Care can range from simply verifying whether a specific medication is available/legal to bring into the country to sourcing specialists and making arrangements to carry out a specialized treatment plan.

A Continuation of Care case can be opened with AXA any time a participant is looking to continue medical treatment in their prospective host country. This can range from simply verifying whether a specific medication is available/legal to bring into the country, to sourcing specialists and making arrangements to carry out a specialized treatment plan. For these cases *AXA will ask that the attached two forms be completed.*

1. The first is a medical form to be completed by the participant's treating physician. It is meant to identify the condition they are seeking to continue treatment for, and verify specifics of the current treatment plan.
2. The second form is a Release of Information (ROI) form that the participant completes and signs. This authorizes the home physician to release medical information to AXA should they need to reach out to them with any questions regarding the medical condition or treatment plan.

To complete the ROI the participant would add the name of their home physician to the top of section B, and their name and date of birth where prompted in the middle of section B. They would then sign and date at the bottom of the form.

Once the forms are completed AXA will work to first verify that the medications the participant is taking are legal/available in the host country. They will provide information as to what documentation they will need to carry with their medication, and the maximum quantity that they are allowed to enter into the host country with. They will then work to identify local specialists in the host country capable of providing the necessary treatment they are looking to continue. Once potential providers have been identified they will then reach out to discuss the proposed treatment with the specialist to confirm that they will be willing to administer the treatment. This is to make sure that we are referring our participant to a specialist that is not only able to provide treatment, but more importantly willing to provide the necessary treatment.

Continuation of Care Cases can be opened with AXA Assistance by phone or email to:

Toll Free: +1-855-327-1411 (US Calls)

Collect: 1-312-935-1703 (International Calls)

Email: medassist-usa@axa-assistance.us

When opening a case the participant should be prepared to provide AXA with their prospective address abroad, or if they do not have a confirmed address they should provide information as the area/city they will be residing in. This is to ensure that AXA is researching and sourcing specialists near to where they will be residing.

If you have any questions, and would like to speak to someone directly at CISI, please email crisis@mycisi.com or call Drew Woods, our Health and Safety Manager, during business hours at 1-203-399-5563.

Your patient has requested our assistance in coordinating ongoing medical treatment while they are traveling outside of the US. To start the process we require the completion of this brief questionnaire. After review by our Medical team, we may be request additional information to share with the potential accepting physician in the destination country. We appreciate your assistance to ensure that your patient has continuity of care while abroad.

To be completed by patient:

Patient Name: _____

Doctor Name: _____

Date of Birth: _____

Diagnosis: _____

To be completed by treating physician:

Current Medication Information:

Name of Medication	Recommended dosage	Date of last administration	Date of next planned administration	Will you be prescribing for the duration of travel? (Y/N)	Medical reason for medication	List any Contraindications of continuing medication regimen while abroad	Acceptable alternate medication, if not available abroad

Past Medical History: _____

When was patient last seen in your office: _____

Recommended treatment plan while abroad (including specialist type and date of next appointment):

Any additional information that would help our office coordinate continuation of treatment for your patient.

Physician Stamp / Signature

Date



Phone : (312) 935-9200 Ext. 2006 Fax : (312) 896-5569 E-mail: medassist-usa@axa-assistance.us

**AUTHORIZATION FOR
DISCLOSURE OF MEDICAL INFORMATION
AXA Reference # :**

A. EXPLANATION

This authorization for disclosure of medical information is being requested from you to comply with the terms of the Confidentiality of Medical Information Act.

B. AUTHORIZATION

I hereby authorize:

to disclose to AXA Assistance, its officers, employees and/or affiliates my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form and that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient name:

Date of Birth:

Date(s) of Service: ALL

Description of information to be released (check all that apply):

All information available

- | | | |
|---|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Radiology Films |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Diagnostic Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Other: | | |

C. USER

The medical records and any other type of information released can be used only for the purpose of Insurance Coverage Verification. The information described herein will be sent to the following address:

**AXA ASSISTANCE USA
122 S Michigan Ave Ste 1100
Chicago, IL 60603**

D. DURATION

I understand that I may revoke this consent at any time before the information has been released by submitting a written request. This revocation request must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

This consent will expire in 180 days unless another date is written here: _____

DATE: _____ **SIGNATURE:** _____

(RELATIONSHIP, IF OTHER THAN THE PATIENT)