Transition/Continuity of Care Coverage Request

ECHS Category - TCRF

Personal and confidential

Fully insured commercial members in California should not use this form.

Applies to:

Aetna plans

All health benefits and health insurance plans offered, underwritten and/or administered by

Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner | Aetna)

Texas Health + Aetna Health Insurance Company and/or Texas Health + Aetna Health Plan Inc. (Texas Health Aetna)

Allina Health and Aetna Health Insurance Company (Allina Health | Aetna)



Here's the form you requested for transition/continuity of care coverage from the health plan. If we approve your request, the health plan will cover ongoing care at the highest level of benefits from

- An out-of-network doctor
- A doctor whose network status has changed
- Certain other health care providers who have treated you

Once we review your completed form, we'll send you a letter explaining our decision.

Some things you should know about transition/continuity of care coverage.
You'll find answers to commonly asked questions about transition/continuity of care coverage on the other side of this form. You should read them before filling out this form.

Transition/Continuity of care coverage does not apply if your provider is in the plan's network (participating) or is part of your plan's highest benefit tier. The online provider search directory is found on the health plan's webpage. It can tell you if your doctor is in the network or help you find a participating provider for your health plan. You can also call us at the phone number on your ID card.

How to complete the form and get it to us

Step 1: Fill out these sections:

1. Section 1 (Plan information). Plan information is on the front of your ID card.
2. Section 2 (Subscriber and patient information):
3. Section 3 (Authorization): Read the authorization, then sign and date the form.
4. (Misrepresentation): NY residents please sign and date **page 6**.

Step 2: Give the form to the **doctor/health care provider** to complete **Section 4 on page 4**, including the diagnostic and treatment information requested on **page 5**.

Step 3: Fax the completed form to us for review. Or you can mail the completed form to the address listed on your ID card. You should complete one form for each health care provider.

Step 4: You can also submit a digital copy of the forms by visiting your member website at Aetna.com. Once you sign in, click **Support > Contact Us > Send a Message**. From the Message Center, click **New Message > Send Message**. From here, choose the message topic **"Other"** and load your completed forms.

Fax medical and mental health/substance use requests to 1-859-455-8650

Be sure to complete all fields on pages 4 and 5. *Your request will be answered faster that way.*

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates.

Transition/Continuity of care coverage questions and answers

Q. What is transition/continuity of care (TOC/COC) coverage?

- **For new members**:

  TOC coverage is temporary. You can get TOC when you become a new member of a medical benefits plan or change your plan, and you are being treated by a doctor who:

  - Is not in the plan's network; or
  - Is not included in Narrow Network, or a plan sponsor specific network, and your benefits change to include one of these networks.

  TOC coverage can also apply when your doctor leaves the plan's network or changes network status or if certain laws or regulations require coverage. Approved TOC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

  TOC coverage is only for the requested doctor. Except in New York, TOC coverage does not include health care facilities, durable medical equipment (DME) vendors or pharmaceutical items. TOC coverage is extended to durable medical equipment (DME) vendors for members in Maryland. If we approve TOC coverage, the doctor must use a health care facility, DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

- **For existing members**:

  COC coverage can also apply when your doctor or facility leaves the plan's network or changes network status or if certain laws or regulations require coverage. Approved COC coverage allows a member who is receiving treatment to continue the treatment **for a limited time** at the highest plan benefits level.

  Except in New York, COC coverage does not include durable medical equipment (DME) vendors or pharmaceutical items. If we approve COC coverage, the doctor must use a DME vendor or pharmacy vendor in the plan's network. If you want to request coverage for a vendor or facility outside the plan's network, call the Member Services phone number on your ID card.

Q. What is an active course of treatment?

A. An active course of treatment means you have begun a program of planned services with your doctor to correct or treat a diagnosed condition. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Some active course of treatment examples may include, but are not limited to members who:

- Are pregnant and has begun a course of treatment (including prenatal care) for the pregnancy from the obstetrician (OB) or facility.
- Are undergoing a course of treatment for a serious and complex condition from the provider or facility, such as chemotherapy or radiation therapy.
- Are or was determined to be terminally ill (if the individual has a medical prognosis that the individual's life expectancy is 6 months or less) and is receiving treatment for such illness from such provider or facility.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance use. (The member must have had at least one treatment session within 30 days before the status of the member or the participating health care provider changed.)
- Have an ongoing or disabling condition that suddenly gets worse.
- May need or have had an organ or bone marrow transplant.
- Are scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.

To be considered for TOC/COC coverage, treatment must have started **before** the enrollment or re-enrollment date, or ***before*** the date your doctor or facility left the health plan's network, or ***before*** the date a doctor's or facility's network status **changed**.

Q. Do I need to complete a form for each provider that I am requesting TOC/COC for?

A. Yes, a separate form is required for each provider.

Q. What other types of providers, besides doctors, can be considered for TOC/COC coverage?

A. This includes health care professionals such as physical therapists, occupational therapists, speech therapists and agencies that provide skilled home care services, such as visiting nurses. TOC/COC is considered for participating hospitals when the facility is not designated for the highest benefit level for plans that include tiered networks or when a participating facility terminates from the network. TOC/COC does not apply to other health care facilities (for example, skilled nursing facility), DME vendors or pharmaceutical items.

Q. If I am currently receiving treatment from my doctor, why wouldn't you approve my request for TOC/COC coverage?

A. To be approved for TOC/COC, the procedure or service must be a covered benefit under the terms of your plan. **For providers that leave the network:** As part of the Federal No Surprises Act, your doctor must accept the terms outlined on the COC request form.

Q. My PCP is no longer a participating provider. If my plan requires me to select a PCP, can I still see my doctor?

A. If you're receiving treatment, you may still be able to visit your PCP, even if he/she leaves the network. In all states, except Texas and New Jersey, you may need to select a PCP in the health plan's network. In Texas and New Jersey, COC may apply to PCPs. Talk to your PCP so that he/she can help you with your future health care needs.

Q. How long does TOC/COC coverage last?

A. Usually, TOC/COC coverage lasts 90 days, but this may vary based on your condition (for example, pregnancy). We will tell you if your TOC/COC coverage request is approved and how long the coverage will last.

Q. How do I sign up for TOC/COC coverage?

A. Contact the Member Services number on your member ID card. You must submit a TOC request form to the health plan:

- Within 90 days of when you enroll or re-enroll
- Within 90 days of the date the health care provider left the plan's network or within 90 days from the date on the letter notifying you of the change
- Within 90 days of a doctor's network status change

You or your doctor can call us or send in the request form.

Q. Does TOC/COC coverage apply if my plan does not have a provider network?

A. No.

Q. What if I have a Narrow Network or plan sponsor specific network plan?

A. If we approve your TOC/COC coverage, you may still receive care at the highest benefits level for a certain time period. If you continue treatment with this doctor after the approved time period, your coverage would be limited to what your plan allows. This means you may have reduced benefits or no benefits.

Q. What if I have more questions about TOC/COC coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC/COC mental health services, you can call the Member Services phone number on your ID card or, if listed, the mental health or behavioral health number.

Q. How will I know if my request for TOC/COC coverage is approved?

A. We will make a decision after we receive your request. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

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☐ **Medical** ☐ **Mental health/substance use**

Please indicate above whether this request is for medical treatment or mental health/substance use treatment.

Form completed by: ☐ Member ☐ Provider

1. Group or employer information (Note: Complete a separate form for each member and/or provider.)

Plan name (please print)	Plan number(s)	Plan effective date

2. Subscriber and patient information

Subscriber's name (please print)	Subscriber's ID number	
Subscriber's address (please print)		
Patient's name (please print)	Birthdate *(MM/DD/YYYY)*	Telephone number
Patient's address (please print)	Plan type/product	
	Telephone number for patient/subscriber submitting request. (Business hours, 9 a.m. – 5 p.m.)	

Request for Transition/Continuity of Care Coverage due to:

New member: ☐ Yes ☐ No **Provider termination:** ☐ Yes ☐ No **If provider termination,** please provide the date of the letter notifying you of the provider terminating from the network and include a copy of the letter with the completed form. *(MM/DD/YYYY)*

3. Authorization

I request approval for coverage of ongoing care from the health care provider named below for treatment started before my effective date with the health plan, or before the end of the provider's contract with the health plan's network, or before the provider's network status change. If approved, I understand that the authorization for coverage of services stated below will be valid for a certain period of time. I give permission for the health care provider to send any needed medical information and/or records to the health plan so a decision can be made.

Patient's signature (**required if patient is age 17 or older**)	Date *(MM/DD/YYYY)*
Parent's signature (**required if patient is age 16 or younger**)	Date *(MM/DD/YYYY)*

4. Provider information (Note: Provide all specific information to avoid delay in the processing of this request.)

Name of treating doctor or other health care provider (Please print)	Tax ID number
Service Address of treating doctor or other health care provider (Please print)	
Contact name of office personnel to call with questions:	Telephone number
Signature of treating doctor or other health care provider	Date *(MM/DD/YYYY)*

The above-named patient is a member as of the effective date indicated above. We understand you are not or soon will not be a participating provider in the health plan's network. The patient has asked that we cover your care for a specific time period. This is because of a condition, such as pregnancy, that is considered an active course of treatment. An active course of treatment is defined as: "A program of planned services starting on the date the provider first renders a service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment and includes a qualifying situation." Please include a brief statement of the patient's current condition and treatment plan. For pregnancies, please indicate the estimated date of confinement (EDC). If we approve this request, you agree:

- To provide the patient's treatment and follow-up
- Not to seek more payment from this patient other than the patient responsibility under the patient's plan of benefits (for example, patient's copayment, deductibles or other out-of-pocket requirements)
- To share information on the patient's treatment with us

You also agree to use the health plan's network for any referrals, lab work or hospitalizations for services not part of the requested treatment. The provider completing the form may not be leaving the network but may request continuing care to be provided by a hospital that is leaving the network.

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Patient's name (please print)	Birthdate *(MM/DD/YYYY)*

Provider: Please complete the diagnostic and treatment information below describing the active course of treatment and attach all clinical documentation to support this request.

ONCOLOGY

Are you in a current course of active treatment (Reconstruction Surgery, Radiation Therapy, Immunotherapy, Targeted Agents, **OR** Chemotherapy) for Cancer with treatment initiated in the last 90 days?

☐ Yes ☐ No Name of drug: _____ DX and description: _____

Expected length of treatment: _____ Visit and next Visit Dates: (mm/dd/yy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

INTRAVENOUS THERAPY COURSE OF TREATMENT REQUEST

Is the member currently receiving intravenous therapy for Antibiotics, **OR** Hyperalimentation/Total Parenteral Nutrition?

☐ Yes ☐ No Treatment Start Date: (mm/dd/yyyy): _____ and Expected End Date: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

SURGICAL FOLLOW-UP REQUEST (POST-OP)

Is this a follow-up with a Surgeon's office and is the member within the 90 days post-operative period **OR** has the member started series of surgical procedures to correct the same condition?

☐ Yes ☐ No Date of Surgery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OBSTETRICAL REQUEST

Is the member pregnant and has completed her first visit with an Obstetrician (OB) office?

☐ Yes ☐ No First OB Visit: (mm/dd/yyyy): _____ Expected Date of Delivery: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

OTHER REQUESTS

Is the member currently in an active course of treatment?

Type of treatment: _____

Treatment Start Date: (mm/dd/yyyy): _____ Last Date of Treatment: (mm/dd/yyyy): _____

Diagnostic and CPT/HCPCS Codes

DX: _____ **CPT/HCPCS:** _____

DX: _____ **CPT/HCPCS:** _____

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents:** ***For your protection California law requires notice of the following to appear on this form:*** *Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.* **Attention Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Attention Maryland Residents:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **Attention North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Attention Washington Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Patient/Member Signature:	**Date:**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: **711**,
Fax: 859-425-3379 (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697** (TDD).

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TTY: 711

English	To access language services at no cost to you, call the number on your ID card.
Albanian	Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով
Bantu-Kirundi	Kugira uronke serivisi z'indimi ata kiguzi, hamagara inomero iri ku karangamuntu kawe
Bengali	আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားပန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.
Cebuano	Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Cherokee	ᏩᎩᏍᏗ ᎦᎾᏂᎯᏍᏗ ᎢᏅᎾᏓᏛᏁᏗ Ꭰ ᎪᎢᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏯᎩ, ᎾᏉᎯᏏᎳᏏᏓᏏᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏥᎨᏗᏘᏢ ᎤᎾ ID ᏗᏂᏲᏍᏗ ᏣᏉᏢT.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Choctaw	Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah
Chuukese	Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Dutch	Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરવો.
Hawaiian	No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.

Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၫ်ဍတၢ်ကမ္ၢ်ကျိာတၢ်မၤစၤၣ်အတၢ်ဖံးတၢ်မၤတဖၣ် လၫ်ဍတအိၣ်ဒီးအပှၤလၫ်နကဘၣ်ဟ့ၣ်အီၤအဂီၤ်ကီးဘၣ်လီတဲစိနိၣ်ဂ်ၢ်လၫ်အအိၣ်လၫ်နခိၣ်ဂီၤ ၈ (၅) အလိၣ်ဘၣ်ကွၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ṇan bōk jipañ kōn kajin ilo an ejjeḷọk wōṇean ñan kwe, kwōn kallok nōṃba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të kɔɔr yïn ran de wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke yïn cɔl ran ye kɔc kuɔny në namba de abac tɔ̈ në ID kard duɔ̈n de tïït de nyin de panakim kɔ̈u.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.

Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian	Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Sudanic Fulfulde	Heeɓa a naasta nder ekkitol jaangirde woldeji walla yoɓugo, ewnu lamba je ɗon windi ha do ɗerowol maaɗa.
Swahili	Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.
Syriac-Assyrian	ܐܢ ܗܣܩܬܐ ܬܠܘܢ ܥܠ ܝܠܚܢ̈ܐ ܕܡܢܝܢܬܐ ܚܠܥܢܐ ܡܟܠܐܢܝܬ، ܩܢܝܚܘܢ ܡܢܝܢܐ ܥܠ ܦܠܩܐ ܡܕܥܢܘܬܐ ܕܒܝܬܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Telugu	భాష సేవలను మీకు ఖర్చు లేకుండా అందుకునేందుకు, మీ ఐడి కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Tongan	Kapau ‘oku ke fiema’u ta’etōtōngi ‘a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati.
Turkish	Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Urdu	لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Yiddish	צו באקומען שפראך סערוויסעס פריי פון אפצאל, רופט דעם נומער אויף אייער ID קארטל.
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.