Transition 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 benefit and insurance plans offered and/or underwritten by Innovation Health Plan, Inc., and Innovation Health Insurance Company

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)

Sutter Health and Aetna Administrative Services LLC (Sutter Health | Aetna)

aetna®

Here's the form you requested for transition-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-of-care coverage
You'll find answers to commonly asked questions about transition-of-care coverage on the other side of this form. You should read them before filling out this form.

Transition-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 DocFind® online provider 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 (Group or employer information).
2. Section 2 (Subscriber and patient information): Plan information is on the front of your ID card.
3. Section 3 (Authorization): Read the authorization, then sign and date the form.
4. (Misrepresentation): NY residents please sign and date page 5.

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

Step 3: **Fax** the completed form to us for review. You should complete one form for each health care provider.

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

Be sure to complete all fields on pages 3 and 4. 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-of-care coverage questions and answers

Q. What is transition-of-care (TOC) coverage?

A. 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
- Is not included in Aexcel, tier 1 (for tiered network plans) or plan sponsor specific networks, 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. 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.

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:

- Enroll with the plan after 20 weeks of pregnancy, unless there are specific state or plan requirements (Members less than 20 weeks pregnant whom the health plan confirms as high risk are reviewed on a case-by-case basis.)
- Have completed 14 weeks of pregnancy or more and are receiving care from a plan's participating practitioner whose network status changes.
- Are in an ongoing treatment plan, such as chemotherapy or radiation therapy.
- Have a terminal illness and are expected to live six months or less.
- Need more than one surgery, such as cleft palate repair.
- Have recently had surgery.
- Are being treated for a mental illness or for substance abuse. (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.

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

Q. What other types of providers, besides doctors, can be considered for TOC 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 is considered for participating hospitals only when the facility is not designated for the highest benefit level for plans that include tiered networks. TOC 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 coverage?

A. If you're receiving treatment, the procedure or service must be a covered benefit. Your doctor must also agree to accept the terms outlined on the TOC 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, TOC 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 coverage last?

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

Q. How do I sign up for TOC 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
- Within 90 days of a doctor's network status change

You or your doctor can send in the request form.

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

A. We will send you a letter via U.S. mail. The letter will say whether or not you are approved.

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

A. No.

Q. What if I have an Aexcel or plan sponsor specific network plan?

A. If we approve your TOC 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 coverage?

A. Call the Member Services phone number on your ID card. If you have questions about TOC 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.

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☐ **Medical** ☐ **Mental health/substance abuse**

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

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

Group or employer's name (please print)	Plan control number	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)*
Patient's address (please print)	Telephone number
	Plan type/product
Telephone number for patient/subscriber submitting request (Business hours, 9 a.m. – 5 p.m.)	Last date of treatment before beginning the health plan coverage (as applicable)

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)	Telephone number
Contact name of office personnel to call with questions	
Address of treating doctor or other health care provider (Please print)	Tax ID 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. In New York state, 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.

Description of all medical and behavioral health-related diagnoses (for example, pregnancy, cancer, depression, post-operative). Include all ICD codes:	**Description of all treatment and procedures. Include all CPT codes:**	**Date of original surgery, if applicable:**	**Date care was initiated:**	**Dates of current treatment:** *(Please provide copies of medical records from the last office visit.)*	**Number of additional visits needed :** *(For pregnancy, please include **EDC**.)*

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 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 act, which is a crime and subjects such person to criminal and civil penalties. **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 and its affiliates comply 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.

Aetna and its affiliates 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	For language assistance in your language call the number listed on your ID card at no cost.
Albanian	Për asistencë në gjuhën shqipe telefononi falas në numrin e regjistruar në kartën tuaj të identitetit (ID).
Amharic	ለአማርኛ ቋንቋ እገዛ በመታወቅያዎ ላይ በተጠቀሰው ቁጥር በነጻ ይደውሉ
Arabic	لتلقي المساعدة اللغوية باللغة العربية، اتصل مجانا بالرقم الموضح على بطاقة الاشتراك في التأمين الصحي.
Armenian	Հայերեն լեզվով օգնություն ստանալու համար կարող էք զանգահարել ձեր բժշկական ապահովվագրական քարտում նշված անվճար հեռախոսահամարով:
Assyrian-Syriac	ܒܟܠ ܠܫܢܐ ܕܐܫܘܪܝܐ ܐܬܨܠ ܒܡܣܦܪܐ ܕܚܐ ܕܡܬܟܬܒ ܥܠ ܟܪܛܝܣ ܕܒܛܝܚܘܬܟ ܕܠܐ ܡܫܠܡ ܐܢ ܐܝܬ ܠܟ ܟܪܛܝܣ ܕܒܝܛܘܚ ܘ ܟܪܛܝܣ ܕܚܝܢ ܠܐ ܡܫܠܡ.
Bahasa Indonesia	Untuk bantuan dalam bahasa Indonesia, silakan hubungi nomor yang tercantum di kartu ID Anda tanpa dikenakan biaya.
Bantu-Kirundi	Niba urondera uwugufasha mu Kirundi, twakure ku busa ku inomero iri ku ikarata yawe y'ugutegekaniriza indwara.
Bengali-Bangala	বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে, তাতে বিনামূল্যে কল করুন।
Burmese	သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားပန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။
Catalan	Per rebre assistència en català, truqui al número de telèfon gratuït que apareix a la seva targeta d'identificació.
Cebuano	Para sa tabang sa lengguwahe sa Binisaya, tawagi ang numero nga nakalista sa imong kard sa ID nga walay bayad.
Chamorro	Para asistensian lengguåhi ni dibåtde, gi fino' Chamoru, ågang i numiru ni gaige gi i iyo-mu ID card.
Cherokee	ᎾᏍᏩᎾ ᏩᎳᎩ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᏩ ᏫᏦᎯᏏᎳᏍᏓᏏ ᎤᎢ ᏗᎪᏍᏗ ᏥᎦᎯᏭᏢ ᎾᎢ ᏩᏙᎩ ID ᎢᎾᏨᏍᏗ Ꮮ ᎪᎢᏍᏗ ᏧEᏀᏩ ᏂᏲᎡᎾ. (ᏩᏢᏏ)
Chinese	欲取得繁體中文語言協助，請撥打您保險卡上所列的號碼，無需付費。
Choctaw	Chahta anumpa ya apela a chi bvnna hokmvt, chi holisso kallo iskitini ma holhtena yvt takanli. Nan aivlli keyu ho ish i payahinla.
Chuukese	Ren áninnisin chiakú ren Kapasen Chuuk kopwe kékkééri ena nampaan tengewa aa makketiw wóón noumw ena chéén taropween ID nge esapw kamé ngonuk.
Cushitic-Omoro	Tajaajila afaan Oromiffaa argachuuf lakkoofsota bilbilaa waraqaa eenyummaa keessan irra jiran irratti bilisaan bilbilaa.
Dutch	Bel voor taalkundige ondersteuning in het Nederlands gratis naar het nummer dat op uw ziekteverzekeringskaart vermeld staat.
French	Pour une assistance linguistique en français, appelez gratuitement le numéro indiqué sur votre carte d'assurance santé.
French Creole	Pou ou jwenn asistans lang pou Kreyòl Ayisyen, rele gratis nan nimewo ki sou kat idantifikasyon asirans sante ou.
German	Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an.
Greek	Για γλωσσική βοήθεια στα Ελληνικά καλέστε χωρίς χρέωση τον αριθμό που αναγράφεται στην κάρτα αναγνώρισης.
Gujarati	ગુજરાતીમાં ભાષા સહાય માટે તમારા આઈડી કાર્ડ પર લખેલ નંબર પર કોઈ ખર્ચ વગર કૉલ કરો.
Hawaiian	No ke kōkua ma ka ʻōlelo Hawaiʻi e kahea aku i ka helu kelepona ma kāu kaleka ID, kāki ʻole ʻia kēia kōkua nei.
Hindi	हिन्दी भाषा में सहायता प्राप्त करने के लिए अपने आईडी कार्ड पर दिये गए नंबर पर मुफ़्त कॉल करें।

Hmong	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau tus xov tooj ntawm koj daim npav.
Igbo	Maka enyemaka asụsụ n’ Ìgbò kpọọ nọmba edèpụtàrà na kaadị njirimara gị na agwụghị ụgwọ ọ bụla.
Ilocano	Para iti language assistance para iti Ilocano awagan ti numero a nakalista ayan iti ID kard yo nga awanan ti bayadna.
Italian	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa.
Japanese	日本語でのアシストは、IDカードに記載の番号に無料でお電話ください。
Karen	လၢကျိာ်တၢ်မၤစၢၤ လၢကညီကျိာ်အဂီၢ် ကိးလိတဲစိနှိာ်ဂၢ်တၢ်ကွဲးလီၤဃာ်လၢနတၢ်မၤနှာ်မၤဃါခးအလိၤ လၢတအိာ်ဒီးတၢ်လၢာ်ဘူာ်လၢာ်စုၤဘာ် နှဉ်တက့ၢ်.
Korean	한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화 번호로 전화해 주십시오.
Kru-Bassa	Bɛ̀ m̀ ké gbo-kpá-kpá dyé ɖé Bǎsɔ́ɔ̀ wùɖùǔn wɛ̃ɛ, ɖá nɔ̀bà bɛ́ ɔ cééà bó nì dyí-dyoìn-bɛ̃̀ɔ̃̀ kɔ̃ɛ bó pídyi.
Kurdish	بۆ هاریکاری زمان تایبەت بە زمانی خۆت پەیوەندی بکەن بە ژمارەی بێ بەرامبەری نووسراو لە کارتی پێناسی خۆتاندا.
Laotian	ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາເບີຢູ່ໃນບັດປະຈໍາຕົວຂອງທ່ານໄດ້ໂດຍບໍ່ເສຍຄ່າ.
Marathi	मराठीतील भाषा साहाय्यासाठी तुमच्या आयडी कार्डवर सूचीबद्ध करण्यात आलेल्या क्रमांकावर मोफत कॉल करा.
Marshallese	Ñan bōk jipañ ilo Kajin Ṃajeļ kwōn kallok nōṃba eo me ej waļọk ilo kaat in ID eo aṃ ilo ejjeļọk wōṇean.
Mon-Khmer, Cambodian	សម្រាប់ជំនួយជាភាសាខ្មែរ សូមទូរសព្ទតាមលេខដែលមាននៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នកដោយឥតគិតថ្លៃ។
Navajo	***Naaltsoos bee néhózinígo nanitinígíí béésh bee hane’é numbo bikáá’ígíí áajį’ hoodílne’ díí saad bee yá’át’igo bee níka’ adoolwołígíí éí t’áá nik’e Diné bizaadjí nił ádoolníił.***
Nepali	नेपालीमा भाषासम्बन्धी सहायता पाउनका लागि तपाईंको परिचय-पत्रमा उल्लेख गरिएको नम्बरमा निःशुल्क कल गर्नुहोस्।
Nilotic-Dinka	Tën ë kuɔɔny ë thok ë Thuɔŋjäŋ, cɔl akuën cï reec ë kaad du kɔ̈u kecïn aɣöc.
Norwegian	For språkassistanse på norsk, ring nummeret på ID-kortet ditt kostnadsfritt.
Pennsylvania Dutch	Fer Helfe in Deitsch, ruf die Fonnummer aa die uff dei ID Kaarde iss. Es Aaruf koschtet nix.
Persian	برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی
Pohnpeian.	Ohng palien sawas en soun kawewe ni lokaian Pohnpei, koahl nempe me sansal pohn noumw ID koard ni sohte isais.
Polish	Aby uzyskać pomoc językową w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie identyfikacyjnej.
Portuguese	Para obter assistência linguística em português ligue para o número grátis indicado no seu cartão de identificação.
Punjabi	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ‘ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।
Romanian	Pentru asistență lingvistică în românește, telefonați la numărul gratuit indicat pe cardul de membru.
Russian	Чтобы получить языковую поддержку на русском языке, бесплатно позвоните по номеру, указанному на вашей идентификационной карте.
Samoan	Mō fesoasoani tau gagana i le Gagana Sāmoa vala’au le numera o lo’o lisiina i luga o lau pepa ID e aunoa ma se totogi.
Serbo-Croatian	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj naveden na poleđini Vaše identifikacijske kartice.

Spanish	Para obtener asistencia lingüística en español, llame sin costo alguno al número que figura en su tarjeta de identificación.
Sudanic-Fulfude	Heɓa wallende be wolde Fulfulde ewne lamba je ɗon windi ha do ɗerewol modon, meere.
Swahili	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa nambari iliyoorodheshwa kwenye Kitambulisho chako bila malipo.
Tagalog	Para sa language assistance na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad.
Telugu	తెలుగులో భాషలో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా మీ ఐడి కార్డు మీద ఉన్న నెంబరుకు కాల్ చేయండి.
Thai	สำหรับความช่วยเหลือทางด้านภาษาเป็น (ภาษาไทย) โทรหมายเลขที่แสดงไว้บนบัตรประจำตัวของท่าน ฟรีไม่มีค่าใช้จ่าย
Tongan	Kapau ‘oku fiema’u hā tōkoni ‘i he lea faka-Tonga telefoni ki he fika ‘oku lisi ‘i ho’o kaati ID ‘o ‘ikai hā tōtōngi
Turkish	Türkçe dil yardımı için kimlik kartınızdaki numarayı ücretsiz olarak arayabilirsiniz.
Ukrainian	Щоб отримати мовну підтримку українською мовою, безкоштовним зателефонуйте за номером, зазначеним на вашій ідентифікаційній картці.
Urdu	**لسانی خدمات تک مُفت رسائی کے لیے، اپنے بیمہ کے ID کارڈ پر درج نمبر پر کال کریں۔**
Vietnamese	Để được hỗ trợ ngôn ngữ bằng tiếng Việt, hãy gọi đến số được ghi trên thẻ ID của quý vị, miễn phí cước gọi.
Yiddish	פאר שפראך הילף אין אידיש רופט דעם נומער וואס שטייט אויף אייער אידענטיטעט קארטל פריי פון אפצאל.
Yoruba	Fún ìrànlọwọ nípa èdè Yorùbá pe nọ́mbà tí a kọ sórí káàdì ìdánimọ̀ rẹ lọ́fẹ̀ẹ́.