Daniel Gottry

September 29, 2006

Ms. Katherine Randall
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11001 N. Black Canyon Hwy, Suite 300
Phoenix, Arizona 85029

To: CIGNA – HealthCare Transition of Care

Thank you for your rapid response to my request for HealthCare Transition of Care Request forms. I received them yesterday! I am submitting this letter as supplemental information related to my request for Transition of Care.

As you know, I am an above knee amputee (2 ½ years) who had received prosthetic care since that time from Pongratz O/P, a CIGNA provider for quite some time. With CIGNA's recent decision to enter into an exclusive contract with LINKIA for the provision of O/P services, Pongratz Orthotics and Prosthetics received their letter of cancellation from CIGNA, effective 10/1/06. To say that this is a disappointment to me is a gross understatement.

Since that time I have been provided with information relative to contracted providers which included two choices:

1. A Hanger Facility (with which my experience has not been positive)
2. McCleve O&P.

I am not familiar with McCleve O&P and was surprised that they were still a contracted provider with CIGNA, given the recent changes. When I asked about the projected longevity of that contract, the response from CIGNA gave the impression that their contract may be short-lived. Since the care provides by a prosthetist is more effective with personal experience and knowledge, the prospect of making two changes eliminates McCleve as a viable option for me.

Based on the following, I am requesting approval of a Transition of Care request for continued services by Pongratz Orthotics and Prosthetics:

- The provision of prosthetic care in my case is not a matter of "hardware" but rather one requiring the skills of a qualified professional who *knows* my situation and history.
- Since the initial amputation, I have been hospitalized for infections two times, both requiring revision surgeries. Since the last surgery, I have been much more sensitive in areas of my leg and Pongratz has exhibited *extraordinary care* in meeting my needs for comfort. The benefit of "history" in my case is critical.
- Mobility issues have also been significant. Because of the issues with my leg prior to amputation and the immobility that occurred during surgery and recovery (with the last surgeries, I was off my leg for four months in summer/fall 2005) there are significant issues related to movement of the residual limb. Together, we have identified very creative ways to deal with the issues in such a manner as to allow for much greater ease of walking.

- I am in the currently in the midst of an ongoing treatment process. We have created test sockets, one specifically designed to allow me to walk on the socket for a period of time. This is allowing my limb to adjust, after which the final corrections will be made. In order to complete that process appropriately, requires a number of additional weeks. To change course midway through the process will be very difficult for me and likely not achieve the success that I anticipate with Pongratz O&P.

Based on this information, I respectfully request approval of my Transition of Care request. If you have any questions, please don't hesitate to contact me.

Sincerely,

Daniel Gottry

P.S. I am confident that Joe Pongratz will be pleased to provide any additional information required.

See instructions for completing this form on the reverse side.

CIGNA HealthCare Transition of Care Request Form

CIGNA HealthCare

ATTENTION: You may not need to complete this form

- **Complete this form only if you are using a provider who does not participate in your CIGNA provider network and you are: (a) undergoing a course of treatment for an acute condition or other condition as described in your plan materials and/or required by state law: or (b) pregnant and in the second or third trimester of pregnancy.**
- See next page for instructions on completing this form. For mental health treatment, please review the information on the reverse page.
- Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employee Name: DANIEL GOTTRY

1. Is the patient pregnant and in the second or third trimester of pregnancy? ☐ Yes ☒ No
2. If yes, when is the due date? _____ (mm/dd/yyyy)
3. Is the patient currently receiving treatment for an acute condition or trauma? ☒ Yes ☐ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with CIGNA HealthCare? ☐ Yes ☒ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy, terminal care or a candidate for organ transplant? ☐ Yes ☒ No
6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☒ No
7. Is the patient receiving mental health/substance abuse treatment? ☐ Yes ☒ No
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care. O/P CARE FOR MOBILITY FOLLOWING REVISION SURGERY
9. Please complete the provider information request below.

Group Practice Name: PRONGRATZ O/P			
Provider's Name: JOE PONGRATZ		Telephone # of Provider: 602-222-3032	
Provider's Specialty: O+P			
Provider's Address: 2530 E THOMAS RD. PHOENIX AZ 85016			
Hospital Where Patient's Provider Practices: N/A		Telephone # of Hospital	
Hospital Address			
Reason/Diagnosis: SEE ATTACHED			
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery	
Treatment Being Received and Expected Duration: 10/1/06 — 6/30/07			

10. Is this patient expected to be in the hospital when coverage with CIGNA HealthCare begins or during the next 90 days? ☐ Yes ☒ No
11. Please list any other continuing care needs that may qualify for Transition of Care benefits. If these care needs are not associated with the condition for which you are applying for Transition of Care benefits, you need to complete a separate Transition of Care Form.

I hereby authorize the above provider to give CIGNA HealthCare or any affiliated CIGNA company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under CIGNA HealthCare. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian: [signature]	Date (mm/dd/yyyy): 09/29/06