Continuity of Care Request Form

See instructions for completing this form on the next page. Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Fund Name		
Member Name		Member ID#
Address Street	City	State Zip Code
Work Phone	Home Phone	Mobile Phone
Patient Name	Patient Date of Birth (mm/dd/yyyy)	Relationship to Member: Spouse ☐ Dependent ☐ Self ☐
Provider Terminating the Member's Network	Provider Type / Specialty	
Provider Office Location Street	City	State Zip Code
Provider Phone Number	Provider Termination Date (mm/dd/yyyy)	

1. Is the patient pregnant? Yes ☐ No ☐
   If so: Due Date _____ (mm/dd/yyyy)
   Is the pregnancy considered high-risk? Yes ☐ No ☐
   Please describe: _____.
   _____.
2. Is the patient currently receiving treatment for an acute condition or trauma? Yes ☐ No ☐
3. Is the patient currently scheduled for surgery or hospitalization with the terminating provider after the provider's scheduled termination from the network? Yes ☐ No ☐
4. Is the patient currently involved in a course of chemotherapy, radiation therapy, cancer treatment, or terminal care with the terminating provider? Yes ☐ No ☐
5. Is the patient currently receiving treatment or follow-up care as a result of a recent major surgery? Yes ☐ No ☐
6. Is the patient currently receiving dialysis treatment? Yes ☐ No ☐
7. Is the patient a candidate for an organ transplant? Yes ☐ No ☐
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient is requesting Continuity of Care: _____
   _____
9. Please list any other continuing care needs that may qualify the patient for Continuity of Care consideration with the departing provider: _____
   _____

I have reviewed the above information and attest to its validity to the best of my knowledge. My signature below referenced authorizes the physician (or other health care professional) to release the appropriate medical records in order to complete this review.	
Signature of Patient, Parent, or Guardian	Date (mm/dd/yyyy)

Return the Continuity of Care request form to the Member Correspondence address on the back of your ID Card

Instructions to complete the Continuity of Care Request Form

How do I fill out the form?

- Be sure to **complete a separate Continuity of Care Request Form for each condition**.
- Make sure to **answer all questions completely**.
- The **patient** who is receiving Continuity of Care must sign the form. If the patient is a minor, a guardian's signature is required.
- To help ensure a timely review of your request, **please return the form as soon as possible**.
- You must apply for Continuity of Care within **30 days** of the date of this notice.
- The first few sections of the form apply to the **member.** When the form asks for the patient's name, enter the name of the person who is receiving care and is requesting Continuity of Care.
- **For Question 8:**
    - Please state the health condition, when it began, and how often you see this health care provider for care relating to the condition.
    - Please be as specific as possible.
    - Please include information about the current or proposed treatment plan and the length of time treatment is expected to continue.
    - If non-elective surgery is scheduled, state the type and proposed surgery date.

Will I be notified of the status of my Continuity of Care Request?

- Yes, you will be notified if your request is approved, denied, or under medical review.

What if my Continuity of Care Request is approved?

- Continuity of Care applies only to the treatment of the medical condition(s) specified on the request form. All other conditions must be cared for by an in-network health care provider for you to receive in-network coverage.
- If your plan includes out-of-network coverage and you choose to continue care out-of-network beyond the approved Continuity of Care period, you will be subject to out-of-network cost-sharing, pre-certification, and other applicable provisions as specified in the Summary Plan Description (SPD) for your coverage.
- The approval of Continuity of Care does not guarantee that a treatment is medically necessary or otherwise waive pre-certification requirements for services. The services you receive under Continuity of Care must still meet your plan’s medically necessary and prior authorization requirements listed in your SPD.

Return the Continuity of Care request form to the Member Correspondence address on the back of your ID Card