Continuity of Care Request Form

INSTRUCTIONS

If your health care provider or facility is leaving the network of your health plan, you may ask your health plan for continued coverage of treatment by that provider or facility at the in-network benefit level for a limited period of time. This is called "continuity of care." State and federal laws require your health plan and the provider to agree to this arrangement for certain types of providers and health care conditions.

You must submit this form to request continuity of care. You and your health care provider must provide all the information requested below to allow your health plan to determine if you qualify for continuity of care under state or federal law.

Please complete a separate form for each provider and health care condition for which you are requesting continuity of care.

MEMBER AND PATIENT INFORMATION

Member's Name		Member's Date of Birth (mm/dd/yyyy)	
Patient's Name (if different)		Patient's Date of Birth (mm/dd/yyyy)	Patient Relationship to Member: ☐ Spouse ☐ Dependent ☐ Self
Street Address		Member ID #	
City		Group Name (If Applicable)	
State	Zip Code	Group # (If Applicable)	
Primary Telephone Number		Secondary Telephone Number (Optional)	

HEALTH CARE PRACTITIONER/FACILITY INFORMATION – to be completed by the provider

Name of Health Care Practitioner/Facility		National Provider Identifier (NPI) or Tax ID Number (TIN)	
Street Address		City	
Telephone Number	Fax Number	State	Zip Code

Is the provider the patient's primary care provider or a provider who rendered behavioral health care services to the patient in the last 3 months? ☐ Yes ☐ No
If yes, the DIAGNOSIS REQUIRING CONTINUITY OF CARE section may be left blank.

DIAGNOSIS REQUIRING CONTINUITY OF CARE – to be completed by the provider

Diagnosis Code(s) (ICD-10)	Date Treatment Started (mm/dd/yyyy)	Date of Next Treatment/Visit (mm/dd/yyyy)
Treatment (including related procedure codes)	If Maternity, Expected Date of Delivery (mm/dd/yyyy)	Expected Length of Treatment
Include a brief statement of the patient's current condition and treatment plan		

SIGNATURES/AUTHORIZATIONS

If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from [CARRIER NAME] and cost-sharing from the patient, as applicable.

Signature of Health Care Provider or Facility Representative	Date (mm/dd/yyyy)

I hereby authorize the above health care provider to give [CARRIER NAME] any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand I am entitled to a copy of this authorization request form.

Patient's Signature (or Parent/Guardian's Signature if Patient is a Minor)	Date: (mm/dd/yyyy)