Continuity of care request form

Continuity of care is a process that allows continued care for members who change plans, or whose plans or provider(s) have been terminated from the participating provider network. Coverage depends on the terms and conditions of your plan.

If you meet certain criteria, you may be eligible to continue treatment with your current doctor. Please review Blue Shield's continuity of care brochure at **blueshieldca.com/forms**.

You can also review the information below to see if you qualify. If you need assistance, please call the Member Services number on your Blue Shield member ID card.

Instructions:

Review Part 1 of this form, which is an overview of how to qualify for continuity of care services. Please note: This is subject to eligibility and the terms and conditions of your plan.

Complete Part 2 of this form, which requests information about treatment the member is undergoing and provider(s) involved in the member's care.

Complete Part 3 by attaching the requested treatment documentation:

- Notes from the initial consultation with the member's provider(s)
- The last three progress notes from the member's provider(s)
- The member's treatment plan

Review Part 4, including the certification and authorization box.

Part 1 – Qualifying medical conditions:

Depending on plan terms and conditions, members may qualify for continuity of care for certain services, such as:

- Inpatient care
- Terminal illness treatment
- An active course of treatment for an acute medical condition, or mental health or substance use disorder, including a maternal mental health condition
- Treatment for a serious and complex condition, or as part of an active course of treatment for a serious chronic condition
- Pregnancy care, regardless of trimester, or postpartum care
- Care of a newborn up to 36 months of age
- Scheduled non-elective surgery

Part 2 – Information about current treatments and providers

Patient information

Name:	Subscriber ID:	
Address:		
City:	State:	ZIP code:
Date of birth:	Relationship to subscriber:	
Primary phone number:	Secondary phone number:	
Is your employer changing your health plan?	☐ Yes or ☐ No	
Previous health insurance company (if applicable):		
Kaiser medical record number (if applicable):		
Date coverage ended:	Is previous health plan still being offered? ☐ Yes or ☐ No	
Name of new health plan:		
New health plan effective date:		

Patient medical information

If pregnant, what is the expected delivery date?		
Name of delivering hospital/facility:		Name of OB/GYN:
Is member currently hospitalized? ☐ Yes or ☐ No		Name of hospital:
Is the member currently receiving home healthcare or hospice? ☐ Yes or ☐ No		
Name of Home Healthcare or Hospice provider:		
Home Healthcare or Hospice provider Tax ID:		
Phone number:	Fax number:	
Does the member have a terminal condition?		
Additional information to be considered		
Please list any additional information to be considered:		

Provider information 1

Requesting provider first and last name:		
National provider identifier (NPI):	Billing tax ID no.	
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Provider specialty:		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 2

Requesting provider first and last name:		
National provider identifier (NPI):	Billing tax ID no.	
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Provider specialty:		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 3

Requesting provider first and last name:		
National provider identifier (NPI):	Billing tax ID no.	
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Provider specialty:		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Facility information (include physical address)

Requesting provider first and last name:		
National provider identifier (NPI):	Billing tax ID no.	
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Provider specialty:		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		

Part 3 – Please attach the following documents for each provider

- Initial consult report from the treating provider(s)
- Current treatment plan
- Last three progress notes

Part 4 – Review

Please note: Blue Shield can only approve continuity of care services upon receipt of the treating provider's signed agreement to:

1) Accept Blue Shield's standard participating provider contracted rate
2) Collect only Blue Shield member's standard copayment/coinsurance
3) Refrain from balance billing Blue Shield members for any amounts resulting from financial disagreements

Member certification, authorization, and signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize a physician, healthcare facility, and other provider of health care, insurance carrier, hospital, or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness which this patient received at any time. This information is collected to evaluate and process this request.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Name of member responding:

Member signature

Date of signature

Phone number where we may reach member:

Return this form by mail to:	**Send this form by fax to:**
Blue Shield of California **Attn: Continuity of Care Team** **P.O. Box 629005** **El Dorado Hills, CA 95762**	**(855) 895-3506**

This facsimile transmission may contain protected and privileged, highly confidential medical information, Personal and Health Information (PHI), and/or legal information. The information is intended only for the use of the individual or entity named above.

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