Blue Advantage
A Medicare Approved PPO

What is Continuity of Care?

Continuity of Care is a service that may be offered to you if you are receiving certain medical care by your physician, hospital or other provider whose contractual relationship with Blue Cross and Blue Shield of Alabama is terminating. This service allows a specified transition period to provide consistent quality medical care. Continuity of Care may be offered as a courtesy and is not a benefit.

If you meet the criteria below, and want to request continued care with that healthcare provider beyond the termination date, please go to **AlabamaBlue.com/BACOC** and download the Continuity of Care form, or call the Customer Service number on the back of your card to request this form.

You may be eligible for Continuity of Care if you have one of the following conditions:

1. Pregnancy – maternity members in the second or third trimester of pregnancy on date of notification letter *(through delivery and postpartum).*
2. Mental Health/Substance Abuse Care – must be an acute episode receiving active treatment *(up to 90 days from date of notification letter).*
3. Organ Specific or Bone Marrow Transplant *(up to 180 days post transplant).*
4. Terminal Medical Condition or Illness *(up to 90 days from date of notification letter).*
5. Chronic Condition – a serious chronic condition requiring active treatment and close monitoring by a physician. A chronic condition persists without cure, worsens over time or requires ongoing treatment to maintain remission or prevent deterioration *(up to 90 days from date of notification letter).*

Consult with your physician to see if your health condition is eligible for continuing care.

If you submit a request form and Blue Cross determines the criteria is met for Continuity of Care, Blue Cross will contact your healthcare provider and attempt to arrange for the provision of covered services. If the healthcare provider does not agree to Blue Cross contractual terms and conditions, Blue Cross may provide limited or no benefits, at Blue Cross' sole option. You may be responsible for the cost of any services rendered by a terminated healthcare provider.

Benefit levels provided as part of Continuity of Care are for the specific illness or condition(s) listed and cannot be applied to any other illnesses or condition(s). You must complete a Continuity of Care request form for each condition and return no later than 30 days after the healthcare provider's termination date.

The decision to offer Continuity of Care is solely Blue Cross and Blue Shield of Alabama's and may be withdrawn at any time. Continuity of Care approval is not a guarantee of future payments or alternative benefits. The availability of benefits is also contingent on the terminated healthcare provider's cooperation with Blue Cross. Payment of benefits is subject to all terms and limitations of the contracts in effect at the time services are rendered or any amendment thereto, including in-network and out-of-network provisions and coverage levels.

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CONTINUITY OF CARE REQUEST

Continuity of Care is a service offered to our members receiving medical care by a physician, hospital or other provider whose contractual relationship with Blue Cross and Blue Shield of Alabama is terminating or has terminated. This service may allow a specified transition period to provide consistent quality medical care while a new provider is identified. Continuity of Care may be offered as a courtesy, at Blue Cross and Blue Shield of Alabama's sole discretion, and is not a benefit under the member's coverage.

Benefit levels provided as part of Continuity of Care are for the specific illness or condition(s) listed and cannot be applied to any other illnesses or condition(s). You must complete a Continuity of Care Request form for each condition and return no later than 30 days after the healthcare provider's termination date.

Patient Information

Patient's First Name	Middle Initial	Last Name	Date of Birth:
Contract Holder's First Name (if applicable)	Middle Initial	Last Name	Relationship to Patient:
Contract Number *(include prefix)*		Group Number	Sex of Patient: ☐ Male ☐ Female
Work Telephone	Home or Cell Telephone	Email	
Address	City	State	Zip

Physician Information *(to be filled out by Physician)*

Physician Name	Physician's Specialty	Individual NPI *(National Provider Identifier)*		
Address	City	State	Zip	Physician's Telephone

1. Is the patient pregnant? ☐ Yes ☐ No
   - If yes, when is the due date? _____ *(mm/dd/yyyy)*
2. Has the patient undergone an organ or bone transplant in the past six months? ☐ Yes ☐ No
   - If yes, when did the transplant occur? _____ *(mm/dd/yyyy)*
3. Medical condition for continuity of care consideration:

   _____

   _____
4. Diagnosis *(also give ICD-9 code)*:
5. Member's Condition and Current Treatment Plan – Please include the anticipated length of time the continuity of care services are requested and any narratives or copies of medical records that will facilitate the evaluation process for your patient:

   _____

   _____

   _____

I support this member's request for continuity of care. As the physician, I understand that should Blue Cross approve this continuity of care service request, Blue Cross and I and/or any terminated facility will need to enter into a continuity of care agreement.

Physician Signature _____ Date *(mm/dd/yyyy)* _____

Hospital Information

Hospital Name *(where patient's doctor practices)*			Hospital Telephone
Address	City	State	Zip

I certify this information is complete and correct to the best of my knowledge.

Each case will be considered individually, and approval is only for treatment of the specific health condition. Benefits are subject to the contractual limitations and exclusions set forth in the member's contract/certificate. Any approval of continuity of care does not extend the contractual benefits in any way except to provide in-network level of benefits for a non-network provider for a temporary time period.

Printed Name of Patient, Parent or Guardian _____ Signature of Patient, Parent or Guardian _____ Date *(mm/dd/yyyy)* _____

Mail to: Blue Cross and Blue Shield of Alabama • P.O. Box 2684 • Birmingham, AL 35283-2684 or **Fax:** 205-402-5727