BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

CONTINUITY OF CARE REQUEST FORM

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 under certain, limited conditions.

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