



CONTINUITY OF CARE REQUEST FORM

Continuity of Care is available to members receiving certain medical care by a physician, hospital or other provider and the termination of certain contractual relationships results in a change in the provider's network status. Continuity of Care allows a specified transition period to provide consistent quality medical care while a new provider and/or new coverage is identified.

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 90 days after the date of notification letter.

Patient Information

Form section for Patient Information including fields for Patient's First Name, Middle Initial, Last Name, Date of Birth, Contract Holder's First Name, Middle Initial, Last Name, Relationship to Patient, Contract Number, Group Number, Sex of Patient, Work Telephone, Home or Cell Telephone, Email, Address, City, State, Zip.

Physician Information (to be filled out by Physician)

Form section for Physician Information including fields for Physician Name, Physician's Specialty, Individual NPI, Address, City, State, Zip, Physician's Telephone.

1. Is the patient pregnant? ... If yes, when is the due date? (mm/dd/yyyy) Yes No

2. Medical condition for continuity of care consideration:

3. Diagnosis (also give ICD-9 code):

4. 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, I and/or any terminated facility will be required to comply with all applicable continuity of care laws and regulations. Physician Signature Date (mm/dd/yyyy)

Hospital Information

Form section for Hospital Information including fields for Hospital Name, 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