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 ADT members receiving medical care by a physician, hospital or other provider who experience a disruption for the following reasons:

- You are a new ADT employee who is moving to BCBS from another carrier
- You are an existing ADT employee whose provider has terminated from the network
- You are an existing ADT employee who moved from the BlueCard PPO network to a BCBS Select Network

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 and is not a benefit under your 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