BlueCross BlueShield of Alabama

# Continuity of Care

## What is Continuity of Care?

Continuity of Care is available to members receiving certain medical care from 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 are identified. 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/COC** and download the Continuity of Care form, or call the Customer Service number on the back of your card to request this form.

### Members may be eligible for Continuity of Care for at least 90 days from the date of the notification letter if they have one of the following conditions:

1. Pregnancy – undergoing a course of treatment for pregnancy.
2. Mental Health/Substance Abuse Care - It must be an acute episode receiving active treatment.
3. Terminal Medical Condition or Illness
4. Serious and Complex Condition – a serious and complex condition means: in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
5. Institutional or Inpatient Care – undergoing a course of institutional or inpatient care.
6. Scheduled Non-Elective Surgery – scheduled to undergo non-elective surgery, including post-operative care with respect to such a surgery.
7. Any other condition eligible for Continuity of Care in accordance with applicable laws.

*For any individual that submits a request form and Blue Cross determines the criteria are met for Continuity of Care, Blue Cross will contact the healthcare provider and arrange for the provision of covered services. The healthcare provider is required by law to agree to Blue Cross contractual terms and conditions during the Continuity of Care period and cannot bill you for amounts in excess of the in-network allowed amounts under the plan.*

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.

**DISCLAIMER:** Continuity of Care approval is not a guarantee of future payments or alternative benefits. 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.

Please complete and return the form to determine if you are eligible. If you have any questions, please call the customer service number on the back of your card.

**Scan for information on free language assistance services.**



MKT220AL-2507

BlueCross BlueShield of Alabama

# 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

| 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 Specialty | Provider Tax ID | Individual NPI *(National Provider Identifier)* |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

1. Is the patient pregnant?..... ☐ YES ☐ NO — If yes, when is the due date? *(mm/dd/yyyy)*

2. Medical condition for continuity of care consideration:

3. Diagnosis (also give ICD-10 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 Coupe Health 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

| 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