Capital

REQUEST FOR CONTINUITY OF CARE

Fax to: 717.346.6870

Section A (this section to be completed by the member)	
Subscriber name:	Employer:
Patient name:	ID #:
Address:	Phone #:
	Member notification date:
Section B (this section to be completed by the treating provider)	
Provider's name:	NPI #:
Address:	Phone #:
	Provider termination date:
Diagnosis/condition being treated: Pregnancy: ☐ Yes ☐ No	
Procedure/services provided:	
Length of time in treatment for this condition? Period of time:_____ # of visits:_____	
Outline of treatment course:	
Disposition:	

(For provider office use only)

Eligibility:

Member may be eligible for up to 90 days of continued care if the member is receiving treatment from the provider for any of the following reasons:

- An ongoing course of treatment for a serious and complex condition, defined as one of the following:
  - An acute illness or condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
  - A chronic illness or condition that is life threatening, degenerative, potentially disabling or congenital.
  - A chronic illness or condition that requires specialized medical care over a prolonged period of time.
- A course of institutional or inpatient care.
- Scheduled for nonelective surgery (including post-operative care).
- Receiving treatment for a pregnancy:
  - First trimester—eligible for 90 days of continued care following notice of provider termination.
  - Second trimester—eligible for continued care through the remainder of the pregnancy, plus six weeks coverage after delivery OR 90 days coverage after delivery if delivery occurs during the second trimester.
  - Third trimester—eligible for continued care through the remainder of the pregnancy, plus 90 days after delivery.
- Receiving treatment for a terminal illness.

Please select one of the following:

The request for continuity of care is based on the member's eligibility and the following:

- ☐ Member is a **Fully Insured Commercial, Exchange, Managed Care,** or **Medicare Advantage** member and is in an ongoing course of treatment with an out-of-network provider with Capital Blue Cross. I agree to provide transitional care up to 90 days from the member's effective date with Capital Blue Cross. I am attaching a medical treatment plan for those 90 days.
- ☐ Member is in an ongoing course of treatment and the provider's network status has changed. I agree to provide care up to 90 days from the date the member received notice of my change in network status under the member's Capital Blue Cross health plan.
- ☐ Member is a Medicare Advantage member who is in an ongoing course of treatment, has a previously approved authorization from another health plan, AND is within 90 days of their effective date with a Capital Blue Cross Medicare Advantage plan.

Location of services:

- ☐ Please check this box if the services will be provided at a facility such as a hospital or surgical center. Provide the name of the facility _____.

  Is this the only place where these services can be provided by you? ☐ Yes ☐ No

Terms and conditions:

Requests for continuity of care are subject to review and approval by Capital Blue Cross. If continuity of care is approved by Capital Blue Cross, the following terms apply:

- Provider will continue to adhere to all Capital Blue Cross' policies, procedures, and quality standards with respect to the services received by the member as if the provider's network status had not changed.
- Provider will accept Capital Blue Cross' network reimbursement rates (and any applicable cost sharing from the member) as payment in full and will not balance bill the member for services provided to the member during the approved period of continued care.
- Provider must provide copies of the member's medical records to Capital Blue Cross or the member's participating primary care provider, or both, prior to the conclusion of the ongoing course of treatment.

Additional comments:

Signature of provider:_____ Date: _____

Signature of patient:_____ Date: _____

Mail completed form to:

Medical Management
Capital Blue Cross
PO Box 773732
Harrisburg, PA 17177-3732

Or fax to:

717.346.6870

Important notice for fully insured individual and employer group plans in Pennsylvania: Advertised health insurance policies or programs may not cover all your healthcare expenses. Read your contract or benefit booklet (certificate of coverage) carefully to determine which healthcare services are covered. Questions? Please call 800.962.2242 or the number on the back of your ID card (TTY: 711).