Continuity of Care Instructions

Ensuring Continuity of Care

You may be eligible for "Continuity of Care" as a new or existing member of CareFirst Blue Choice, Inc. if you or any covered dependent(s):

- Are undergoing a program of treatment for a serious, complex condition;
- Are undergoing a course of institutional or inpatient care;
- Are scheduled to undergo a non-elective surgery;
- Are pregnant and undergoing a course of treatment for a pregnancy, or;
- Are determined to be terminally ill.

Please read below to learn more about Continuity of Care at CareFirst and what you may need to know about your rights and responsibilities.

Who should use this form?

If you or your covered dependent(s) have a medical condition that requires a course of treatment or follow-up care or are pregnant, you should complete this form. Information is required from both you and your physician.

If your request qualifies for Continuity of Care based on your current situation, the process allows you or your covered dependent(s) to continue to receive care from an out-of-network provider/facility for up to 90 days.* Benefits will be paid at the in-network level.

- Current members may be covered for up to 90 days from the notification date received from the terminated provider.
- New members coming from another carrier may be covered for up to 90 days from notification date to CareFirst.

Please be sure to submit a separate form for each non-participating provider/facility currently treating you or your covered dependent(s) for your pregnancy or a medical condition or a chronic or disabling condition.

Please complete the Insurance, Patient Information and Physician Information sections. Return the form according to the Instructions Section.

Qualified medical professionals in the CareFirst Case Management Department will review the request. In certain situations, a determination by phone may occur within two business days following the receipt of all required information, If the services do not qualify for Continuity of Care, you and your provider will also be notified in writing.

*Treatment of pregnancy through postpartum care is covered in network. This may be more than 90 days.

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Continuity of Care Request Form

CareFirst BlueChoice

INSTRUCTIONS

Mail the completed form and any attachments to: CareFirst BlueCross BlueShield, Utilization Review, 1501 South Clinton Street, 8th Floor, Mail Stop: CT-08-02, Baltimore, MD 21224

Or fax the completed form and any attachments to: 410-720-3060, Attention: Utilization Review

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

SECTION 1—POLICY HOLDER INFORMATION

◯ New CareFirst member (transitioning from another carrier) ◯ Existing CareFirst member (provider no longer in the network)		Type of request? ◯ Behavioral Health ◯ Medical ◯ Substance Use	
Policy Holder's Name*		Date of Birth*	Home Phone*
Street Address*		City	State / ZIP Code
Group Name		Group #*	Effective Date of Coverage
Member ID #*	Check one ◯ HMO ◯ POS ◯ PPO	Date of Notification	Notification Received via ◯ USPS ◯ Email

SECTION 2—PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

Is the patient seeking treatment for any of the following conditions/illnesses?

Life threatening ◯ Yes ◯ No	Acute condition ◯ Yes ◯ No	Transplant ◯ Yes ◯ No	Inpatient ◯ Yes ◯ No	Surgery ◯ Yes ◯ No
Disabled ◯ Yes ◯ No	Terminal ◯ Yes ◯ No	Ongoing treatment ◯ Yes ◯ No	If yes, frequency of visits:	

Is the patient pregnant? ◯ Yes ◯ No If yes, what is the due date?

If you answered "no" to all the questions above, please describe, to the best of your ability, the condition for which the patient needs Continuity of Care.

SECTION 3—PROVIDER/FACILITY INFORMATION

Name of Provider Currently Treating Condition*		Specialty	Procedure Code, if known
Diagnosis/ICD10* (if known)	Date Treatment Started	Date of Next Treatment/Visit	Date of Termination, if known
Street Address*		Please attach the following: ◯ List of services that may already be scheduled in the next few weeks (date and provider) ◯ A brief statement of the patient's current condition and treatment plan ◯ Copies of any pertinent documentation (e.g., lab results, X-rays)	
City / State / ZIP Code			
Phone*	Fax*		
Tax ID (if known)	NPI (if known)	Note: You may need to work with your provider to obtain this information.	

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SECTION 4—SIGNATURES

This information will be used for determining the appropriate level of benefit reimbursement if I continue treatment with the above named provider for the above diagnosis/medical condition.

I understand that Continuity of Care is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Continuity of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

*If the patient is younger than 12, the policy holder must sign this form.

Patient's Signature	Date
Policy Holder's Signature*	Date
Provider signature (applicable if transitioning from another carrier.)	Date

OFFICE USE ONLY—COC begin and end date