Request for Continuity of Care Services

blue of california

If you are a Blue Shield 65 Plus[SM] (HMO) or Blue Shield 65 Plus Choice Plan (HMO) member, please call Member Services for more information at **(800) 776-4466** [TTY: 711], 7 a.m. to 8 p.m., seven days a week from October 1 through February 14. After February 14, your call will be handled by our automated phone system on weekends and holidays.

Initial criteria must be met:

- **Current Member** – Currently receiving care and your provider is no longer in the plan's network.
- **New Member** – Currently receiving care and your current provider does not accept your new health plan.

Secondary criteria must be met:

- **Acute Condition** – A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.
- **Scheduled Surgery/Procedure** – Surgery or another procedure which has been recommended and documented by the provider and scheduled to take place within 180 days of the enrollee's effective date or provider termination date and authorized for continued care by Blue Shield of California.
- **Newborn/Infants** – Newborn to 36 months of age, general pediatric or specialist care until the earlier of 12 months from the effective/provider termination date or the date the child is 36 months of age.
- **Pregnancy** – The duration of the pregnancy and the immediate postpartum care.
- **Serious Chronic Condition** – A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over time or requires ongoing treatment to maintain remission or prevent deterioration.
- **Terminal Illness** – An incurable or irreversible condition that has a probability of causing death within one year or less. Terminal illness is covered for the duration of the terminal illness.

Subscriber information

Subscriber's name:		
Address:		
City	State	ZIP code
Date of birth:	Subscriber ID number:	
Home phone number:	Cell phone number:	

Patient information

Member's name (if different):		
Address:		
City	State	ZIP code
Date of birth:	Relationship to subscriber:	
Home phone number:	Cell phone number:	

Provider information 1

Requesting provider first and last name:		
Provider address:		
City	State	ZIP code
Provider specialty:		
Provider phone number:	Provider fax number:	
Condition/diagnosis being treated:		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 2

Requesting provider first and last name:		
Provider address:		
City	State	ZIP code
Provider specialty:		
Provider phone number:	Provider fax number:	
Condition/diagnosis being treated:		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 3

Requesting provider first and last name:		
Provider address:		
City	State	ZIP code
Provider specialty:		
Provider phone number:	Provider fax number:	
Condition/diagnosis being treated:		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 4

Requesting provider first and last name:

Provider address:

City	State	ZIP code

Provider specialty:

Provider phone number:	Provider fax number:

Condition/diagnosis being treated:

Original start date with provider:

Date of last office visit/treatment:

Date of next appointment/treatment:

Medical Information

If pregnant, what is the expected delivery date?

Name of delivering hospital:	Name of OB/GYN:

Is member currently hospitalized? ☐ Yes or ☐ No

Is member currently receiving home health care or hospice? ☐ Yes or ☐ No

Name of home healthcare provider or hospice:

Phone number:

Does the member have a terminal condition? ☐ Yes or ☐ No

Additional information to be considered

Please list any additional information to be considered:

Member certification, authorization, and signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize a physician, healthcare facility, and other provider of health care, insurance carrier, hospital, or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness, which this patient received at any time. This information is collected to evaluate and process this request.

Name of member responding:

Member signature

Date of signature

Phone number where we may reach you:

For communication by email, please include your email address:

To return this form by mail:	To return this form by fax:
Blue Shield of California Attn: Continuity of Care Team, P.O. Box 629005, El Dorado Hills, CA 95762	**(855) 895-3506**

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above.

If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that was faxed in error.

Thank you for your help in maintaining appropriate confidentiality.

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