blue california
Promise Health Plan

Request for Continuity of Care Services

Blue Shield of California Promise Health Plan ("Blue Shield Promise") provides continuity of care services to new and current Medi-Cal plan members who have transitioned from a fee-for-service (FFS) Medi-Cal plan into a Medi-Cal managed care plan (MCP), or who have been receiving care from a provider who is no longer in Blue Shield Promise's provider network. Continuity of care will be provided in accordance with state law and the health plan with some exceptions, which are listed under "Exceptions" in this document.

This form may be completed and submitted by a healthcare provider or by a Blue Shield Promise representative on behalf of the Medi-Cal member. This form is not intended to be presented to a Medi-Cal member for the member to complete and submit.

Continuity of care requests

All Blue Shield Promise Medi-Cal members with pre-existing provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months, or for the time required to complete the course of treatment, whichever period of time is shorter, with an out-of-network Medi-Cal certified provider. If more than 12 months of continuing treatment is determined by Blue Shield Promise to be needed, the member is entitled to continue treatment with the pre-existing provider until Blue Shield Promise can arrange for a safe transfer to a new care provider within the Blue Shield Promise network.

When a provider leaves Blue Shield Promise or is an out-of-network provider

Eligible members may require continuity of care services they have been receiving through Medi-Cal fee-for-service (FFS) or another MCP. Blue Shield Promise must provide the continuity of care healthcare services with an out-of-network, certified Medi-Cal provider, or Medi-Cal certified provider organization, if the following requirements are met:

Blue Shield Promise is able to determine that the member has a pre-existing relationship with the healthcare provider.

- A pre-existing relationship means the member has visited the out-of-network primary care provider or specialist for a non-emergency visit or other qualifying service at least once during the 12 months prior to the date of initial enrollment, or prior to the date the provider left the Blue Shield Promise network.

- Blue Shield Promise requires medical records documentation to validate the pre-existing relationship between the provider and the member. Self-attestation by the member is not sufficient to provide proof of the pre-existing relationship.

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Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association L52000-W-PHP (1/20)

1. The out-of-network provider meets Blue Shield Promise's applicable professional standards and has no disqualifying quality of care issues.

2. The provider is a California state plan approved Medi-Cal provider.

3. The provider supplies Blue Shield Promise with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

4. If the out-of-network provider does not join the Blue Shield Promise network by the end of 12 months, does not agree to Blue Shield Promise payment rates or does not meet quality of care requirements, the member will need to switch to providers in the Blue Shield Promise network.

Initial eligibility criteria

- **Current Blue Shield Promise members**
  A Blue Shield Promise Medi-Cal member is currently receiving a specific course of treatment from a Blue Shield Promise network healthcare provider, and the provider leaves the network.

- **Newly enrolled Blue Shield Promise members**
  A new member has a pre-existing relationship with a certified Medi-Cal provider who is not in Blue Shield Promise's Medi-Cal network.

One or more required secondary criteria

- **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.

- **Newborns/Infant (newborn to 36 months old) –** Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee

- **Pregnancy: The duration of the pregnancy and the immediate postpartum care** – Completion of covered services shall be provided for the duration of the pregnancy.

- **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. Completion of treatment for an amount of time required to finish the course of treatment and to arrange for a safe transfer to a new doctor in the Blue Shield Promise network.

- **Terminal illness** – An incurable or irreversible condition that has a high probability of causing death within one year or less. Terminal illness is covered for the duration of the terminal illness. This service is provided for as long as the illness lasts. Completion of covered services may exceed twelve (12) months from the time the care provider stops participating in Blue Shield Promise's provider network.

Secondary criteria, cont'd.

- **Maternal Mental Health Condition** – A mental health condition that can impact a woman during pregnancy, peri- or post-partum, or that arises during pregnancy, in the peri- or post-partum period, for up to one year after delivery.

- **Surgery or other procedures** – A surgery or other procedure which has been authorized by Blue Shield Promise as part of a documented course of treatment and has been recommended and documented by the healthcare provider to occur within 180 of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

Exceptions

Blue Shield Promise is not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protection does not extend to the following supplies or services:

- Durable medical equipment
- Transportation
- Other ancillary services
- Carved-out service providers

Requirements for processing continuity of care requests

In order for the request to be considered as complete, the request must meet the criteria described above, and must include all patient and provider information requested in the form in this document.

In addition, the following documents must be submitted to Blue Shield Promise:

- Current treatment plan applicable to the continuity of care request
- Progress notes from most recent visit
- Documentation of any pending procedures

Please complete all sections of this form on each page.

Subscriber Information		
Subscriber's name:		
Address:		
City:	State:	ZIP code:
Date of birth:	Subscriber ID number:	Kaiser ID number (if applicable):
Home phone number:	Cell number:	Employer group name:
Name of previous health insurance company:		Date coverage ended:
Was the previous health coverage plan you indicated above no longer being offered? Yes No		

Patient Information		
Member's name (if different from subscriber):		
Address:		
City:	State:	ZIP code:
Date of Birth:	Relationship to subscriber:	
Name of previous health insurance company:		Date coverage ended:
Was the previous health coverage plan you indicated above no longer being offered? Yes No		

Provider Information		
Requesting provider first and last name:		National provider identifier (NPI):
Billing tax ID number:		
Provider address:		
City:	State:	ZIP code:
Provider specialty:		
Provider phone number:	Provider FAX number:	

Provider Information, cont'd.

Are you currently enrolled as a Medi-Cal provider with the Department of Healthcare Services (DHCS)?

Yes No

Are you willing to negotiate a letter of agreement (LOA) with Blue Shield Promise? Yes No	Contact name:
	Phone number:
	FAX number:

Condition/diagnosis being treated, including ICD-10 codes:

Treatment CPT codes:

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 the member currently hospitalized? Yes No

If yes,
name of hospital:

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

If yes, name of home health care provider or hospice provider:	Tax ID number:
	Phone number:

Does the member have a terminal condition? Yes No

Additional information to be considered

Please list any additional information to be considered, below:

Providers may complete and return this completed form by fax to Blue Shield Promise at (855) 895-3506.

This facsimile transmission may contain protected and privileged, highly confidential medical information, 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.

TBSP12421 (2/22)
Prov_22_026