Information on Continuity of Care Instructions

Ensuring Continuity of Care

CareFirst BlueChoice members and their covered dependent(s) who are undergoing a course of treatment for a condition, undergoing a course of institutional or inpatient care, are scheduled to undergo a nonelective surgery, pregnant and undergoing a course of treatment for a pregnancy, or determined to be terminally ill may be eligible for Continuity of Care even when the provider or facility is no longer in the plan network.

What is Continuity of Care?

If your request is approved, the Continuity of Care process allows you or your covered dependent(s) to continue to receive care from an out-of-network physician for up to 90 days (or through post partum care) following the date of notification that the provider is no longer in the plan network. Benefits will be paid at the in-network level.

Who should use this form?

If you or your covered dependent(s) have a medical condition that requires a limited course of treatment or follow-up care or are pregnant, and are currently being treated by a specialist who is no longer a CareFirst BlueChoice participating provider, you should complete this form. Information is required from both you and your physician.

Please be sure to submit a separate form for each non-participating physician currently treating you or your covered dependent(s) for your pregnancy or a medical condition or a chronic or disabling condition. Your newly selected participating CareFirst BlueChoice physician must coordinate any other unrelated treatment for you or your covered dependent(s).

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

Qualified medical professionals in the CareFirst BlueChoice Care Management department will review the request and notify you of a determination by phone following the receipt of all required information. If the services are not approved, you and your provider will be notified in writing.

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Request for Continuity of Care Form

CareFirst BlueChoice

INSTRUCTIONS

Mail the completed form and any attachments to: CareFirst BlueChoice, Utilization Management, 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 Management

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.

Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**.

INSURANCE INFORMATION

Member's Name		Date of Birth	
Street Address		Member ID #	
City		Group Name	Effective Date of Coverage
State	Zip Code	Group #	Check one ◉ HMO ○ POS ○ PPO
Home Telephone		Date on Notification	Received via ○ USPS ○ Email

PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

PHYSICIAN INFORMATION

Name of Physician Currently Treating Condition			Diagnosis	Date Treatment Started
Specialty			Procedure	Date of Next Treatment/Visit
Date of Termination, if applicable			For pregnancy, please indicate the patient's anticipated due date	
Street Address			Please attach the following: ○ List of services that may already be scheduled in the next few weeks (date, 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		
Telephone	Fax			
Physician's Signature		Date	OFFICE USE ONLY—COC begin and end date	

This information will be used for determining the appropriate level of benefit reimbursement for services provided on or after the effective date of using my CareFirst coverage, 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 18, the employee/retiree must sign this form.

Patient's Signature	Date:
Employee/Retiree's Signature*	Date