BlueCross BlueShield Federal Employee Program

Continuity of care request form (California)

Continuity of care is a process that allows continued care for members who change plans. It also applies when plans or provider(s) have been terminated from the participating provider network. Coverage depends on the terms and conditions of your plan.

If you meet certain criteria, you may be eligible to continue treatment with your current doctor. Review the information below to see if you qualify. If you need help, call the Customer Service Prior Authorization number on your Blue Cross Blue Shield Federal Employee member ID card.

Instructions:

Review Part 1 of this form, which is an overview of how to qualify for continuity of care services. Note: This is subject to eligibility and the terms and conditions of your plan.

Complete Part 2 of this form, which requests information about the treatment our member is undergoing and the provider or facility involved in the member's care.

Complete Part 3 by attaching the requested treatment documentation:

- Notes from the initial consultation with the member's provider
- The last three progress notes from the member's provider
- The members' treatment plan

Review Part 4 and complete the certification and authorization box.

Part 1 – Qualifying medical conditions:

Depending on the plan terms and conditions, members may qualify for continuity of care for certain services that began prior to the termination date, such as:

- Terminal illness treatment.
- An active course of treatment for an acute medical condition, maternity care, mental health or substance use disorder. These must require prompt medical attention over a limited amount of time during which care can be transferred to a contracting provider.
- Treatment for a serious and complex condition, or as part of an active course of treatment for a serious chronic condition, not to exceed 12 months from effective date of the provider's termination date.
- Pregnancy care in the 2nd and 3rd trimester, or postpartum care (up to 10 weeks after delivery date).
- Care of a newborn up to 36 months of age that does not exceed 12 months from effective date of the provider's termination date.
- A surgery or other treatment that was recommended and documented by the provider to take place within 90 days of provider's termination date, was started or planned prior to the providers termination date and was authorized by Blue Shield of California.
- Inpatient Care when the member is hospitalized on the date of termination or as part of an urgent or emergency admission until member is stable to transfer to a contracting provider.

Part 2 – Information about current treatments and providers

Patient information

Full Name:	Member ID:	
Address:		
City:	State:	ZIP code:
Date of birth:	Relationship to member:	
Primary phone number:	Secondary phone number:	
Is your employer changing your health plan?	☐ Yes or ☐ No	
Previous health insurance company (if applicable):		
Date coverage ended or is ending:	Is the previous health plan still being offered? ☐ Yes or ☐ No	
Name of new health plan:		
New health plan effective date:		

Patient medical information

If pregnant, what is the expected delivery date?	
Are members currently hospitalized? ☐ Yes or ☐ No	Name of hospital:
Is the member currently receiving home healthcare or hospice? ☐ Yes or ☐ No	
Does the member have a terminal condition? ☐ Yes or ☐ No	
Is the member being actively treated for an acute medical condition? ☐ Yes or ☐ No If "Yes" name of the acute condition:	
Is the service scheduled within the 90-day grace period after provider termination date? ☐ Yes or ☐ No If "Yes" date of surgery/procedure:	
Is the member being actively treated for a chronic condition? ☐ Yes or ☐ No If "Yes" name of the chronic condition:	
Is the member a newborn under 3 years of age? ☐ Yes or ☐ No	

Additional information to be considered

Please list any additional information to be considered:

Provider information

Billing provider first and last name:		
If billing under group; Group Name:		
National provider identifier (NPI):	Billing tax ID no.	
Will the Provider or Group be billing on a ☐ HCFA CMS 1500 Form or ☐ UB Form		
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Provider specialty:		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Facility Information: If care is to be provided in a facility, please complete the section below

Billing facility name:		
National provider identifier (NPI):	Billing tax ID no.	
Address:		
City:	State:	ZIP code:
Phone number:	Fax number:	
Will the Facility be billing on a ☐ HCFA CMS 1500 Form or ☐ UB Form		
Condition/diagnosis being treated (ICD-10 code, if available):		
Treatment (CPT code(s), if available):		
Original start date with facility:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Part 3 – Please attach the following documents.

- Current progress notes from the member's provider(s); and
- Member's treatment plan (if separate)

Part 4 – Review

Please note: Blue Shield can only approve continuity of care services upon receipt of the treating provider's signed agreement to:

1) Accept Blue Shield's standard participating provider contracted rate.
2) Accept Blue Cross standard participating facility contracted rate.
3) Collect only the member's standard copayment/coinsurance.
4) Refrain from balance billing the members for any amounts resulting from financial disagreements

Member certification, authorization, and signature

I certify that all statements on this and all attached 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.

For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Name of member responding:

Member signature

Date of signature

Phone number where we may reach member:

Return this form by mail to:	Send this form by fax
Blue Shield of California **Attn: FEP Continuity of Care Team** **3300 Zinfandel Dr** **Rancho Cordova, CA 95670**	**to: (855) 479-9483**

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.

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