Continuation of Care Form

Continuation of Care

If you are receiving ongoing treatment for certain acute medical or serious chronic conditions — for example, a first-trimester pregnancy, chemotherapy, dialysis, or transplant, you may be eligible for transition of care benefits. These benefits let you continue care with a non-network provider for a limited period under certain circumstances. If approved, your care is generally covered as in-network for a set period.

You can apply for transition of care benefits. Submitting the completed form to Anthem is a request for consideration of Continuation of Care and must be reviewed and approved by Anthem to determine if the particular situation meets the transition of care requirements under the plan.

- Generally, transition of care will continue for no more than 120 days
  - Pregnancy — If you are pregnant, the transition of care will cover your out-of-network provider through your delivery date at in-network reimbursement levels.
  - Extended cycles of care — If you are undergoing an extended cycle of care (e.g. a transplant) that is completed in phases over time, you will receive the transition of care benefit for the entire cycle of care.

Continuation of Care Conditions

- **An acute medical condition** is 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 that has a limited duration.
- **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- Pregnant, regardless of trimester;
- You have a terminal illness;
- You have a surgery or other procedure that has been authorized by the previous plan and is scheduled to occur within 180 days of the effective date of coverage with Anthem.

Please send completed forms to the following Address:

Anthem BlueCross BlueShield

Attn: National Continuation of Care Coordinator
P.O. Box 7101
Indianapolis, IN 46207-7101

- Phone Number: 1-800-354-6948.
- Fax: 1-317-287-6464.

To help ensure that your care is not disrupted, please complete the entire form below. Only complete this form if you are receiving ongoing care or are scheduled for care. **For Medical or Behavioral**

Health Care: If you are changing to the Anthem PPO and your current medical or behavioral health provider is in the Anthem Blue Cross Blue Shield provider network, you do not need to complete this form**.**

Fill out the form completely, and do not leave any blanks. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscribers' Name					
Subscriber's ID #					
Employer					
Date Active with Anthem					
Patient's Name					
Relationship to Subscriber					
Home Phone#					
Cell Phone #					
Work Phone #		Ext:		Date of Birth	
Hospital or Provider's name:					
Diagnosis (including pertinent history and physical findings)					

1 Do you have an upcoming appointment to see a specialist? Yes/No
If yes, please provide the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for pregnancy				
Hospital for delivery:				
Due Date:				
Other: Please be specific				

2 Are you currently receiving any of the following services? Yes/No

Services	Facility or Company, Medical or Behavioral Health Provider
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3 Do you have any hospitalizations, surgeries or procedures scheduled? Yes/No

Date _____

Type of Surgery/Procedure _____

Name/Phone Number of Physician performing surgery/procedure _____

Hospital/Facility _____

4 Have you been admitted to the hospital or seen in the emergency room in the past 6 months? Yes/No

Reason _____

Hospital _____

Date(s) of Service _____

I herby authorize the above provider to give Anthem BlueCross BlueShield any and all information and medical records necessary to make an informed decision concerning my request for Continuation of Care Benefits under Anthem BlueCross BlueShield. I understand I am entitled to a copy of this authorization form. I also authorize Anthem BlueCross BlueShield to leave confidential information on my voice mail at the following number(s) listed above, please check all that apply:

Home Cell Work

Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over

Date

Signature of Parent or Guardian if Patient is under 18 over

Date