# Provider Termination
# Continuity of Care Request Form

Anthem
And Its Affiliate HealthKeepers, Inc.

## Form completion tips

Complete and submit a *Continuity of Care Request Form* if your doctor or other health care provider is leaving your plan. It is important that your care is not disrupted while you look for a new doctor who is in your plan's network. You may be eligible to keep receiving care for certain conditions or scheduled services for a limited time.

Please do not complete and submit the form if you are not currently receiving ongoing care or if you do not have upcoming services scheduled.

Please complete and submit a *Continuity of Care Request Form* if any of the circumstances listed below apply:

- You are in treatment for a serious and complex condition. (This can be a sudden illness that requires specialized treatment in order to avoid death or permanent harm. It can also be an ongoing illness that is life threatening or potentially disabling and requires specialized care over a long period of time.)
- You are in a hospital or other inpatient facility.
- You are scheduled for non-elective surgery by your current doctor, including your post-operative care for the surgery.
- You are pregnant.
- You are terminally ill.

If you have questions or need help, please call us at the Member Services number on your ID card.

**Please mail or fax this completed form to:**

| Mailing address | Fax number |
|---|---|
| Anthem Blue Cross and Blue Shield<br>Medical Management<br>Mail Drop VA44A<br>P.O. Box 27401<br>Richmond, VA 23279 | 866-552-9777 |

# Provider Termination
# Continuity of Care Request Form

Anthem®
And Its Affiliate HealthKeepers, Inc.

**Instructions —** Complete this form only if you are receiving ongoing care, or are scheduled to receive care, and your provider is leaving the Anthem network. Please complete a separate form for each family member who may need continuity of care.

## Subscriber information

| Last name | First name | M.I. | Anthem member ID |
|---|---|---|---|
| | | | |

## Patient information

| Last name | First name | M.I. | Date of birth (MMDDYYYY) |
|---|---|---|---|
| | | | |

| Preferred phone no. | Secondary phone no. |
|---|---|
| ( ) ☐ Home ☐ Cell ☐ Work | ( ) ☐ Home ☐ Cell ☐ Work |

Diagnosis requiring continuity of care (include pertinent history and physical findings)

## Medical information

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

| Type | Physician name (last, first)/ Physician phone no. | Physician address | Date of next office visit/ Reason |
|---|---|---|---|
| Heart specialist | Name:<br>Phone: | | Date:<br>Reason: |
| Lung specialist | Name:<br>Phone: | | Date:<br>Reason: |
| Blood or cancer specialist | Name:<br>Phone: | | Date:<br>Reason: |
| Neurologist | Name:<br>Phone: | | Date:<br>Reason: |
| Surgeon | Name:<br>Phone: | | Date:<br>Reason: |
| Obstetrician for pregnancy<br>Due date: | Name:<br>Phone: | | Date:<br>Reason: |
| Other – please be specific:<br>_____ | Name:<br>Phone: | | Date:<br>Reason: |

## Medical information – Continued

**2.** Are you currently receiving any of the following services?

| | | |
|---|---|---|
| Oxygen | ☐ Yes ☐ No | Company: _____ |
| IV medication | ☐ Yes ☐ No | Company: _____ |
| Home therapy | ☐ Yes ☐ No | Company: _____ |
| Inpatient rehab treatment | ☐ Yes ☐ No | Company: _____ |
| Medical equipment | ☐ Yes ☐ No | Company: _____ |
| Dialysis | ☐ Yes ☐ No | Company: _____ |
| Laboratory | ☐ Yes ☐ No | Company: _____ |
| Radiation therapy | ☐ Yes ☐ No | Company: _____ |
| Other – please be specific: _____ | ☐ Yes ☐ No | Company: _____ |

**3.** Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No

Date: ___ ___ / ___ ___ / ___ ___ ___ ___ Type of surgery/procedure: _____

Name/phone no. of physician performing surgery/procedure: _____

Hospital/facility: _____

**4.** Other needs/comments: _____

**If you answered yes to any of the questions above, you will be contacted to coordinate your continuity of care, if appropriate.**

## Signature required

I authorize Anthem Blue Cross and Blue Shield to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the Anthem Blue Cross and Blue Shield reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand that the Anthem Blue Cross and Blue Shield reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

| Signature of patient if age 18 or over<br>**X** | Printed name | Date (MMDDYYYY)<br>___ ___ / ___ ___ / ___ ___ ___ ___ |
|---|---|---|
| Signature of parent or guardian if patient is under age 18<br>**X** | Printed name | Date (MMDDYYYY)<br>___ ___ / ___ ___ / ___ ___ ___ ___ |

Reset Form Save and Print