Anthem

Continuation of Care Form

GENERAL INFORMATION ABOUT TRANSITION ASSISTANCE PROGRAM

Purpose of Continuation of Care
Transition Assistance is a process that allows continued care for members when:

- Their primary medical group, IPA, PPO provider, hospital, or other provider is terminated from the participating provider network.
- They are a new enrollee in an Anthem plan (except members with an Individual contract) and their treating provider is not part of the participating provider network.
- Continuity of care is at risk for reasons over which the member has no control.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact your Anthem Customer Service.

Completing the Continuation of Care Form
You may request Continuation of Care if:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. **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 or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

Please send completed forms to the following:

- Address: **Anthem BCBS National Accounts**
  15 Plaza Dr
  Mail Drop NY59-15-3L-9999
  Latham, NY 12110
  Attn: General Dynamics Medical Management Team

- Phone Number: **1–844–274–9561**
- Fax: **1–888–438–7061**

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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 Care****: If you are currently in a PPO or EPO and are changing to an Anthem PPO or EPO and your current medical provider is in our network, or if you are in a HMO and are changing to an Anthem HMO and will stay in your current Medical Group or IPA, you do not need to complete this form****.*** ***For Behavioral Health Care****: If you are changing plans and your provider is not in the Anthem network, please 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: _____ Circle the type of terminating plan: HMO, PPO, EPO, CDHP

Diagnosis (include 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 Due Date: Hospital for delivery:				
Other: Please be specific				

Anthem

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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 _____

5. Other Needs _____

I herby authorize the above provider to give select a name based on region performing UM/BH management with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under select name based on region. 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