Instructions for completing the continuity of care coverage request form

Please

- Do not use this form if you are in a Medicare and/or Medicare supplement program. You will need to contact your Medicare Administrator for further assistance.
- Complete a separate form for each policyholder or dependent who is requesting continuity of care coverage.
- Fill in **all the blanks for each section.**

Section: Patient information

- This section (including the patient's name) should be completed for the member who will receive the care.

Section: Physician information

- It is not required that this section be filled out by a provider; however, the process will be expedited if it's filled out by the treating provider and/or facility. **The member must already be under the care of this provider for the condition stated** in this request to be considered for continuity of care coverage.
- Please include provider name, address, phone number, and National Provider Identification (NPI) and/or Tax Identification Number (TIN).
- If you are the treating provider, please provide any attachments/clinical documentation that **may be helpful** for the review of this request.

Section: Facility/Treatment center

- Please provide Facility name, National Provider Identification (NPI) and/or Tax Identification Number (TIN), and address where treatment is provided.

Note: This continuity of care coverage request does not replace a precertification, nor does it certify medical necessity. The information provided on the request for continuity of care coverage form will be used for determining whether treatment and/or conditions listed on the form qualify for continuity of care coverage.

Please fax the completed form and any attachments to **501-301-1993**, Attention: **Clinical Review** or email the completed form and any attachments to: clinicalresearchteam@arkbluecross.com.

Questions?

If you have any questions concerning benefits or provider status, please contact Member Services.
The phone number is listed on the back of your member ID card.

Request for continuity of care

Instructions

Fax the completed form and any attachments to: **501-301-1993**, Attention: **Clinical Review**

Or email the completed form and any attachments to: clinicalresearchteam@arkbluecross.com.

Please complete a separate form for each policyholder or dependent who is requesting continuity of care coverage.

If you have questions concerning benefits or provider status, contact customer service at the phone number listed on the back of your member ID card.

Patient information

Patient's name	**Date of birth** (mm/dd/yyyy)	**Effective date of coverage**

Street or P.O. box	**City**	**State**	**ZIP**

Phone	**Member ID number**	**Email**

Physician information

To expedite the request, please have your physician complete the below information

Name of physician currently treating condition(s)	**Phone**

Street or P.O. box	**City**	**State**	**ZIP**

Specialty	**Physician TIN/NPI**	**Procedure code(s) (CPT/HCPCS)**	**Date of next treatment/visit**

Diagnosis code(s) (ICD-10)	**Date treatment started**

For pregnancy, please indicate if high risk	**Due date**	**Weeks gestation**

Facility/Treatment center

Name of facility/treatment center	**Facility TIN/NPI**

Street or P.O. box	**City**	**State**	**ZIP**

Please attach a list of the following:

- List of services that may already be scheduled in the next few weeks (with CPT code, date and provider)
- A brief statement of the patient's current condition(s) and treatment plan(s)

Signatures

Physician's signature	**Date signed**

The information provided on this form will be used for determining whether treatment listed for the above condition(s) qualifies for continuity of care coverage and the appropriate level of reimbursement for services provided on or after the effective date of my Arkansas Blue Cross and Blue Shield, Health Advantage and/or BlueAdvantage Administrators of Arkansas coverage, if I continue treatment with the named provider for the diagnosis or procedure codes referenced in this form.

I understand that continuity of care coverage is granted at the discretion of Arkansas Blue Cross, Health Advantage and/or BlueAdvantage and is subject to any contractual limitations and exclusions in the benefit plan. This continuity of care exception applies only to the physician listed above, regarding medical conditions, and/or treatment plans listed, for the lesser of 90 days or the end of the treatment.

I hereby authorize the above healthcare provider to give Arkansas Blue Cross or its affiliates or contracted parties any and all information and medical records necessary to make an informed decision concerning my request for continuity of care coverage. I understand that I am entitled to a copy of this authorization request form.

By signing below, I agree that a copy of the dispensation of this application will be shared with the provider referenced within this application by **mail or email.**

Please send the decision about this application to:

- My email
- My mailing address
- Both my email and my mailing address

Patient's signature (if age 18 or older)	**Date signed**
Policyholder/Guardian's signature	**Date signed**

Any person who knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.