Group Termination
Continuity of Care Request Form

Anthem

Form completion tips

Complete and submit a *Continuity of Care Request Form* if your Anthem health plan ended because your employer's contract with us terminated. It is important that your care is not disrupted during this change to a new health plan. If you aren't enrolled in a new health plan, or your doctor is not in your new plan's network, you may be eligible to keep receiving care for certain conditions or scheduled services.

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 fax this completed form to:

Type of request	Fax number
For medical requests	877-214-1781
For behavioral health requests	877-521-4787
For applied behavior analysis services	866-582-2287

Group Termination
Continuity of Care Request Form

Anthem

Instructions — Complete this form only if you are receiving ongoing care, or are scheduled to receive care, and you are not enrolled in a new health plan. Or, if your doctor isn't in your new plan's network. Please complete a separate form for each family member who may need continuity of care.

Subscriber information (of terminated Anthem plan)

Last name	First name	M.I.	Anthem member ID
Subscriber employer name	Date coverage ended: (MMDDYYYY)		

Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)
Preferred phone no. ( ) ☐ Home ☐ Cell ☐ Work	Secondary phone no. ( ) ☐ Home ☐ Cell ☐ Work		
New health insurance company			Effective date (MMDDYYYY)
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: Phone:		Date: Reason:
Lung specialist	Name: Phone:		Date: Reason:
Blood or cancer specialist	Name: Phone:		Date: Reason:
Neurologist	Name: Phone:		Date: Reason:
Surgeon	Name: Phone:		Date: Reason:
Obstetrician for pregnancy Due date:	Name: Phone:		Date: Reason:
Other – please be specific: _____	Name: Phone:		Date: 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 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 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 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 **X**	Printed name	Date (MMDDYYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MMDDYYYY)