Continuation of Care Form

Our goal is to provide benefits for continuity of care for any new member of Anthem Blue Cross and Blue Shield who is receiving prenatal care or is in ***active*** *treatment ,for an acute or chronic condition with a* provider who has left the Anthem Blue Cross and Blue Shield Network. Visits through the current period of active treatment **or** up to 90 days, depending on the care needs and circumstances will be approved. If the member chooses to continue her prenatal care with an out of network provider, the visits may be approved if the member is receiving prenatal care during the second or third trimester of pregnancy and will continue through the provision of post-partum care directly related to the delivery.

If you or any covered family member are receiving care of this kind from a non participating provider, please complete this form. Information provided will be kept confidential by Anthem Blue Cross and Blue Shield and will only be used in accordance with applicable privacy laws. Anthem Blue Cross and Blue Shield may share this information with your primary care provider (PCP) and/or specialist and may be in contact with you to facilitate continuity or continuation of care.

Subscriber/Employer Info: Subscriber Name: _____ Coverage Effective Date:_____ Group Number: _____
Employer Name: _____ Type of Coverage, i.e., (HMO, PPO) _____

Patient Info: Patient Name: _____ Patient DOB: _____
Patient ID#_____ Home Telephone #:_____ Work Telephone#_____
Patient Address: _____
Best time to contact:_____

Provider Info Primary Care Physician (PCP): _____
PCP Address: _____
PCP Telephone #: _____

1) Specialist Physician Name: _____ Telephone #: _____
Specialist Address: _____

2) Specialist Physician Name: _____Telephone #_____
Specialist Address: _____

Services Requested for Continuation of Care:

___	Ambulatory/Same Day Surgery	___	Durable Medical Equipment	___	GYN/infertility
___	Hospice Care	___	Inpatient Care (after surgery)	___	Mental Health
___	OB _____ Date of Delivery	___	Oncology	___	Out of Network Care
___	Outpatient Rehab (physical therapy, occupational therapy, speech therapy)				
___	Pediatrics	___	Surgery/Treatment Type of Surgery_____		
___	Transplant	___	Other: _____		
___	Chronic/Long Term Illness, name of illness_____				

Diagnosis:_____

Brief Description of active treatment being received: _____

Are you working with a nurse case manager with your Health Plan at this time? Yes/No

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If yes, what health care needs are being addressed?_____

Would you like to be contacted by the Case Management Department at Anthem to discuss your health care needs? Yes/No

Signature of Subscriber/Guardian/Parent of the Patient: _____
Date: _____

Please mail completed form to: **Attention Medical Management Department**
Anthem BCBS-Medical Management Dept.
108 Leigus Road
Wallingford, CT 06492

(or) fax to: **Medical Management at: 877 539 3851**

Note: For questions on filling out the form or if you need assistance on filling out the form please contact the number on the back of your ID card.