CareFirst
Family of health care plans

Continuity of Care Instructions

For patients in a Maryland based plan

Welcome to CareFirst

One of your concerns as you seek enrollment in a CareFirst BlueCross BlueShield (CareFirst) and/or CareFirst BlueChoice, Inc. (CareFirst BlueChoice) plan may be continuity of treatment. CareFirst and CareFirst BlueChoice patients and their covered dependent(s) who receive care from an out-of-network physician may be eligible for the Continuity of Care process.

What is Continuity of Care?

If your request qualifies for Continuity of Care, the process allows you or your covered dependent(s) to continue to receive care from an out-of-network provider/facility for up to 90 days following the date of enrollment. Benefits will be paid at the in-network level.

Who should use this form?

If you or your covered dependent(s) have a medical condition that requires a limited course of treatment or follow-up care, and are currently being treated by a provider/facility who is not a CareFirst and/or CareFirst BlueChoice participating provider, you should complete this form.

Please be sure to submit a separate form for each non-participating provider/facility currently treating you or your covered dependent(s).

Note: If the provider/facility treating your condition participates in the CareFirst and/or CareFirst BlueChoice network, it is not necessary to complete this form. Instead, contact your new primary care physician to discuss the current treatment.

Examples of medical conditions that may qualify for the Continuity of Care process include:

- Pregnancy
- Bone fractures
- Recent heart attack
- Other acute trauma or surgery
- Joint replacement
- Cancer
- Other serious medical conditions where the member is in active treatment

Examples of chronic medical condition that typically are not eligible for the Continuity of Care process include:

- Allergies
- Arthritis
- Asthma
- COPD/emphysema
- Diabetes
- Hypertension

Return the form to the address listed in the instructions section.

Qualified medical professionals in the CareFirst and CareFirst BlueChoice Care Management Department will review the request and make a determination following the receipt of all required information. If the services do not qualify for Continuity of Care, you and your provider will also be notified in writing.

CUT9155-1E (10/23)

Continuity of Care Request Form

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INSTRUCTIONS

Mail the completed form and any attachments to: CareFirst BlueCross BlueShield, Utilization Review, 1501 South Clinton Street, 8th Floor, Mail Stop: CT-08-02, Baltimore, MD 21224

Or fax the completed form and any attachments to: 410-720-3060, Attention: Utilization Review

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

SECTION 1—POLICY HOLDER INFORMATION

Policy Holder's Name		Date of Birth	Home Phone
Street Address		City	State / ZIP Code
Group Name		Group #	Effective Date of Coverage
Member ID #	Check one ◯ HMO ◯ POS ◯ PPO	Date on Notification	Received via ◯ USPS ◯ Email

SECTION 2—PATIENT INFORMATION

Patient's Name	Patient's Date of Birth
Is the patient pregnant? ◯ Yes ◯ No	If yes, what is the due date?
Is the patient scheduled for a surgical procedure or hospitalization? ◯ Yes ◯ No	
Is the patient undergoing a course of treatment for a serious medical condition at a provider's office or facility? ◯ Yes ◯ No	
Did the patient have a recent major surgery that resulted in a continued course of treatment? ◯ Yes ◯ No	
Is the patient being treated for a terminal illness? ◯ Yes ◯ No	
If you answered "no" to all the questions above, please describe, to the best of your ability, the condition for which the patient needs Continuity of Care.	

SECTION 3—PROVIDER/FACILITY INFORMATION

Name of Provider Currently Treating Condition		Specialty	
Diagnosis	Date Treatment Started	Date of Next Treatment/Visit	Date of Termination, if known
Street Address		Please attach the following: ◯ List of services that may already be scheduled in the next few weeks (date and provider) ◯ A brief statement of the patient's current condition and treatment plan ◯ Copies of any pertinent documentation (e.g., lab results, X-rays)	
City	State / ZIP Code		
Phone	Fax		

SECTION 4—SIGNATURES

This information will be used for determining the appropriate level of benefit reimbursement if I continue treatment with the above named provider for the above diagnosis/medical condition.

I understand that Continuity of Care is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Continuity of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

*If the patient is younger than 18, the policy holder must sign this form.

Patient's Signature	Date
Policy Holder's Signature*	Date

OFFICE USE ONLY—COC begin and end date