BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Continuity of Care Form

Patient Name_____ Date_____
Date of Birth_____ Blue Cross NC ID #_____
Address_____
Telephone Number (home) (_____)_____ (work) (_____)_____
Employer/Group Name _____

***** Please complete one Continuity of Care form per member of household *****

Continuity of Care (CoC) is designed to assist members and eligible dependents in the continuation of their care from a provider who is no longer in-network. To be eligible for CoC, one of the following conditions must apply:

- Serious and complex condition
  - Acute illness (required specialized medical treatment to avoid death or permanent harm)
  - Chronic illness (life threatening, degenerative, potentially disabling, or congenital requiring treatment over a prolonged period of time)
- Course of institutional or inpatient care
- Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Terminally ill

Requests for CoC will be reviewed by a medical professional and will be based on the information provided on this form about specific medical conditions. You have 45 days to request CoC from the date of the provider termination date. Notification about eligibility for CoC will be sent after a decision is made. If your request is approved, you may continue to see your current provider through the timeframe specified in your authorization. Blue Cross Blue Shield of North Carolina (Blue Cross NC) will assist members with finding an in-network provider for any future services before the applicable transition period expires.

- If you are currently receiving care for covered mental health or substance abuse services, and you are enrolled in or enrolling in ***Blue Care,*** **please call 1-800-359-2422** to determine if Continuity of Care is applicable.
- If you are currently receiving care for covered mental health or substance abuse services, and you are enrolled in or enrolling in ***Blue Options, Blue Options HRA or Blue Options has,*** **please call 1-800-672-7897** to determine if Continuity of Care is applicable.

If you are eligible for Continuity of Care according to the list above, please complete the following:

1. The applicable questions on page 2 of this form
2. Return form via mail to:

Blue Cross and Blue Shield of North Carolina
Care Management
PO Box 2291
Durham, North Carolina 27702 -2291

Or fax to us at: 1- 800-228-0838

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What is your medical condition? _____

If you received a notification of provider termination from Blue Cross NC:

1. What is the provider termination date?_____
2. What is the date of the letter? _____

*****Please complete ONLY the sections below that apply to you or your dependent*****

1. Do you have an **existing certification or authorization** for medical services? If yes, please provide the following information.
   What services are you receiving?_____
   Name of Provider _____Phone # ( ) _____
   Provider's Address _____

2. Are you **confirmed pregnant by your provider and actively receiving prenatal care or postpartum care** (delivered within the last two months)? If yes:
   Name of Provider_____Phone# (__)_____
   Provider's Address _____
   Due Date_____Hospital_____
   Next Appointment Date_____

3. Are you being treated or expect to be treated as an **inpatient (hospital, skilled nursing or rehabilitation facility)**? If yes:
   Name of Inpatient Facility_____
   Anticipated Admission Date_____
   Name of Provider _____Phone # (___)_____
   Provider's Address _____
   Anticipated Treatment / Surgery_____

4. Are you receiving **outpatient care** for an acute, chronic, or terminal condition? If yes:
   What services are you receiving?_____
   Where are you receiving the services?_____
   Date of Scheduled Appointment(s)_____Date of Last Service_____
   Name of Provider rendering the services_____

5. Are you scheduled to have a **non-elective surgery**? If yes:
   What is the procedure and date it is scheduled?_____
   Name and address of provider rendering the service_____
   Name of facility where procedure will be performed_____

6. Do you have **home care services and/or durable medical equipment** in the home (e.g., oxygen, a wheelchair, etc.) that is currently being paid for by your medical benefit plan? If yes:
   What services or equipment do you have? _____
   Name and address of agency_____
   Name of Ordering Provider_____

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Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es elinglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del Seguro para obtener ayuda.