Continuity of Care / Transition of Care Request Form (California)

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity / Transition of Care
The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization Provider (PPO Provider), Hospital, or other provider is terminated from the Anthem Blue Cross participating provider network.
- They are a newly covered enrollee to Anthem Blue Cross and their treating provider was part of their previous plan's participating provider network but is not part of the Anthem Blue Cross participating provider network.
- Continuity of care is at risk for reasons over which the member has no control.

Please Note: Members who have **elected** to make changes in their coverage which cause their treating provider to be non-participating are not eligible for this program.

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select a participating provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact Anthem Blue Cross Member Services.

Completing the Continuity / Transition of Care Request Form
You may request Continuity/Transition of Care for completion of covered services by the non-participating treating provider for the following conditions:

- **An acute condition.** An acute condition is a medical or behavioral health condition that involves a sudden onset of symptoms due to an illness, injury or other medical or behavioral health problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- **A serious chronic condition.** A serious chronic condition is a medical or behavioral health condition due to a disease, illness, or other medical or behavioral health problem or medical or behavioral health disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health plan in consultation with the enrollee and the terminated provider or non-participating provider and consistent with good professional practice.
- **A pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **A terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
- **The care of a newborn child between birth and age 36 months.**
- **Performance of a surgery or other procedure** that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the Member Services number on the back of your Anthem Blue Cross card or the Member Services number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Or, fax this completed **California** request form to 1-877-214-1781.

To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care.* ***For Medical Care****: If you are changing to a PPO or EPO and your current medical provider is in our network, or if you are changing to an HMO or POS and will stay in your current PMG or IPA, you do not need to complete this form. If you are in an HMO or POS and your provider is leaving the PMG/IPA, you do not need to complete this form, you need to contact your PMG/IPA and they will assist you with your transition to a contracting provider.* ***For Behavioral Health Care****: If you are changing plans and your provider is not in the Anthem network, please complete this form.*

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Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name: _____ Subscriber's Anthem Blue Cross ID #: _____

Subscriber's Employer: _____ Date Active with Anthem Blue Cross: _____

Patient's Name: _____ Relationship to Subscriber: _____

Date of Birth: _____ Allergies: _____

Preferred Phone #: _____ ☐ Home ☐ Work ☐ Cell Secondary Phone #: _____ ☐ Home ☐ Work ☐ Cell

Name of Terminating Insurance Plan: _____

Type of Terminating Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐ OTHER

Member ID and/or Medical Record Number of Terminating Insurance Plan: _____

New Anthem Blue Cross Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐OTHER

Are You a New Enrollee to Anthem Blue Cross: ☐Yes ☐No

Name of PMG/IPA with Terminating Plan: _____ Name of New Anthem Blue Cross PMG/IPA: _____

For Network Disruption (PMG, IPA, PPO Provider, or Hospital has terminated from the Anthem Blue Cross Participating Provider Network) please provide the name of the terminating Hospital or Provider: _____

Diagnosis (include pertinent history and physical findings): _____

_____

1. Do you have an upcoming appointment to see a specialist? ☐Yes ☐No

If yes, please provide the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for pregnancy Due Date: Hospital for delivery:				
Other: Please be specific				

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2. Are you currently receiving any of the following services? ☐Yes ☐No

If yes, please provide the applicable information below.

Services	Facility or Company, Medical or Behavioral Health Provider
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐Yes ☐No

Date _____ Type of Surgery/Procedure _____

Name/Phone Number of Physician performing surgery/procedure _____

Hospital/Facility _____

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? ☐Yes ☐No

Reason _____ Hospital _____

Date(s) of Service _____

5. Other Needs _____

I hereby authorize the above provider to give the Anthem Blue Cross Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the Anthem Blue Cross Transition Assistance Department and/or Care Management may share information and discuss my care with my new Primary Care Physician/Medical Group under my Anthem plan. I understand that I am entitled to a copy of this authorization form. I also authorize Anthem Blue Cross to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:

☐Home ☐Cell ☐Work ☐Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over: Date:

Signature of Parent or Guardian if Patient is under 18: Date: