SHARP HEALTH PLAN

Request for Continuity of Care

Continuity of care means you receive continued services, under certain conditions, with your current health care provider until your health care provider completes your care.

Newly Enrolled Sharp Health Plan Members:
You may receive continuity of care services in the following situations:

1. When you are receiving care from a non-Sharp Health Plan provider.
2. When your previous coverage terminated due to:
   a. The health plan withdrawing from the market in your service area.
   b. The health plan ceasing to offer the applicable health benefit plan in your service area.

Current Sharp Health Plan Members:
You may receive continuity of care services in the following situations:

1. When your Sharp Health Plan Network has changed.
2. When your Plan Medical Group, hospital or health care provider is no longer contracted with Sharp Health Plan.

Continuity of care may be provided when you or your family member is in an active course of treatment for the following conditions:
(1) Acute condition; (2) Serious chronic condition; (3) Pregnancy; (4) Terminal illness; (5) Pending surgery or other procedure;
(6) Care of a newborn child between birth and age 36 months.

Important Notes: Your requested health care provider must agree to provide continued services to you, subject to the same contract terms and conditions and similar payment rates to other similar health care providers contracted with Sharp Health Plan. You are **not** eligible for continuity of care coverage in the following situations:

- You are a newly enrolled member and had the opportunity to enroll in a health plan with an out-of-network option.
- You had the option to continue with your previous health plan, but instead voluntarily chose to change health plans.
- You have an Individual, Medicare, CalChoice, or CCSB (Covered California for Small Business) policy, and had the ability to choose a plan that allowed you to stay with your health care provider.

Fill out this form if you would like to request continuity of care services. Please submit a separate form for each provider. Incomplete forms will be returned and delay processing of your request.

Please submit your finished form(s) by mail, in person or by fax:

By Mail or In Person:
Attention: Medical Management
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: Medical Management
(619) 740-8111

Patient Treatment Information

Patient name:	Birth date (MM/DD/YY): (/ /)
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other (Please specify)	
Condition currently being treated:	
Treatment received for condition:	

Continue →

Requested Provider

Name:		Specialty:
Address:		
City:	State:	ZIP Code:
Phone number: ( )	Date of last visit (MM/DD/YY): (/ /)	
Do you have an appointment scheduled? ☐ Yes ☐ No	If Yes, what is the date of your appointment? (MM/DD/YY): (/ /)	
Did you have surgery in the past year or have a surgery scheduled? ☐ Yes ☐ No	If Yes, specify the surgery and date (MM/DD/YY): (/ /)	
Expected due date (if applicable, MM/DD/YY): (/ /)	Hospital (if applicable):	

Subscriber and Plan Information

Subscriber name:		Birth date (MM/DD/YY): (/ /)
Effective date with Sharp Health Plan (MM/DD/YY): (/ /)	Home address:	
City:	State:	ZIP Code:
Home phone number: ( )	Name of prior insurance:	
Current employer:	Work phone number: ( )	
May we call you at: ☐ Home ☐ Work		

Continue →

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By completing this document, you authorize the disclosure and/or use of your individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize ______________________________________ (Name of Physician or Health Care Provider) to furnish to Sharp Health Plan medical records and information pertaining to medical history, condition, services renders, or treatment of ______________________________________ (Name of Patient). This authorization applies to the following information (check one box only):

- ☐ All health information including diagnosis, providers, treatments, and drugs
- ☐ Only limited information

  Specify type of information:

  ____

  Specify date range (MM/DD/YY to MM/DD/YY):

  ____

Federal and State laws require us to obtain specific authorization to release especially sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results, psychiatric care, and treatment for alcohol or drug abuse. We will automatically try to exclude these types of information unless you specifically identify them for release. Please check below if you authorize Sharp Health Plan to release any or all of the following sensitive information.

I also specifically authorize the release of the following types of sensitive information (check boxes for all that apply):

☐ Psychiatric Care ☐ Substance Abuse Treatment ☐ HIV and AIDS Test Results

EXPIRATION

This authorization will expire on (MM/DD/YY): (______/______/______)

If no expiration date is selected, this document will be in effect until I send a written request to revoke this authorization.

Continue →

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization.
- I may revoke this authorization at any time by notifying Sharp Health Plan in writing. My revocation will be effective upon receipt but will not be effective to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- I understand that Sharp Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization, except under limited circumstances described in the Notice of Privacy Practices.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and might not be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.
- I understand that Sharp Health Plan may not use or disclose my PHI other than for the purposes described on this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- I hereby release Sharp Health Plan from any and/all liability that may arise from the release of this information to the party named on this form.
- **I understand that this request for Continuity of Care Benefits will be reviewed by Sharp Health Plan through its regular and appropriate utilization review process, and administered consistent with my Sharp Health Plan benefit plan. I will receive written approval or denial of this request from Sharp Health Plan. I understand that the requested services are not approved by Sharp Health Plan unless specifically authorized in writing. I also understand that if my request is denied, I have the right to appeal that decision.**

Patient name:	Patient signature:	Date (MM/DD/YY):
	x	(/ /)

INTERNAL USE ONLY

Date received (MM/DD/YY): (/ /)