Continuity/Transition of Care Request Form
California

Anthem

Continuity of care and **transition of care** are ways of making sure that if you're already in the middle of treatment or scheduled for treatment, you may be able to continue care with your current provider for a limited period of time, despite your provider terminating from the network or if you change health plans.

Anthem may offer you transition/continuity of care options when:

- Your primary medical group (PMG), independent physician association (IPA), preferred provider organization (PPO) provider, hospital or other provider leaves or is terminated from your health plan. That's called **continuity of care**.
- You're a newly covered member to Anthem Blue Cross and the doctor or other provider for your treatment is not part of your new Anthem Blue Cross plan. That's called **transition of care**.
- There are other reasons that you have no control over, which puts the continuity of your care at risk.

The option is NOT available if you:

- Have chosen to make changes to your coverage, in which your doctor or other provider is no longer in your plan.
- Require ongoing care for a chronic condition, but you're not in an acute phase of an illness requiring a special course of treatment.

In these cases, there's no need to fill out this form. Instead, contact Member Services at the number on your Anthem ID for support with finding a doctor or other provider who can give you the care you need. If your doctor is leaving your Anthem PMG or IPA, contact your medical group directly and they will assist you with finding a new primary care doctor. If you are changing plans and your current medical provider is in our network, you're all set.

Health conditions where continuity or transition of care is considered:

An acute condition. A medical or behavioral health condition that involves a sudden onset of symptoms due to an illness or injury — or one that requires prompt medical attention (but for a limited time). Completion of covered services shall be provided for the duration of the acute condition.

Serious chronic condition. A medical or behavioral health condition due to a disease, illness or other medical or behavioral health problem or disorder that is serious and continues without a full cure, worsens over time or requires ongoing treatment to keep it in remission or from getting even worse. 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. Completion of covered services will be considered for a limited period of time not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

Pregnancy. You can complete covered services for the three trimesters of your pregnancy and the immediate postpartum period.

Maternal mental health condition. A mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. For an individual who presents written documentation of being diagnosed with a maternal mental health condition from their treating health care provider, completion of covered services for the maternal mental health condition will be considered for a limited period of time, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later.

Terminal illness. An incurable or irreversible condition that has a high probability of causing death within one year or less. You can complete covered services, even if the duration of the terminal illness goes longer than 12 months from the contract termination date or from the effective date of coverage for a new enrollee.

Care of a newborn child between birth and 36 months old. Completion of covered services will be considered for a limited period of time, not to exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

Surgery or other procedure that has been authorized by the 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 the above situations apply to you, call Anthem Blue Cross Member Services to request continuity/transition of care OR for help in filling out this form to help make sure your care is not interrupted.

For medical requests for California members, fax this completed form to 1-877-214-1781.

For behavioral health requests for California members, fax this completed form to 1-877-521-4787.

For applied behavior analysis services for California members, fax this completed form to 1-866-582-2287.

Continuity of Care: Application New Enrollee and Application Network Disruptions consolidated herein.

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Help us review your request by:

1. **Filling out the form completely and not leaving any blanks. Use "N/A" if the question doesn't apply to you.**
2. **Using a separate form for each family member who needs to have care transitioned to another provider.**

Subscriber/Patient information

Subscriber last name	First name	M.I.	Subscriber ID, if issued
Subscriber employer name			Date active with Anthem (MM/DD/YYYY)
Patient last name	First name	M.I.	Relation to subscriber
Date of birth (MM/DD/YYYY) / Gender	Allergies		
Preferred phone no. ☐ Home ☐ Work ☐ Cell	Secondary phone no. ☐ Home ☐ Work ☐ Cell		

Are you a new enrollee to Anthem? ☐ **Yes** ☐ **No** **If Yes, please fill in the green-shaded areas a) and b). If No, skip to the yellow-shaded area c).**

a) 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: _____
Name of PMG/IPA with terminating plan: _____ Name of new Anthem Blue Cross PMG/IPA: _____

b) New Anthem Blue Cross plan: ☐ HMO ☐ Vivity ☐ POS ☐ PPO ☐ EPO ☐ CDHP ☐ Other: _____

c) Please provide the name of your doctor or hospital canceling your care or terminating with Anthem Blue Cross: _____

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 address	Provider phone no.	Date of next office visit	Reason
Obstetrician for pregnancy					
Due date: ___ ___ ___ ___ (MMDDYYYY) Hospital for delivery: _____					
Applied behavior analysis (ABA) provider					
Blood or cancer specialist					
Heart specialist					
Infectious disease specialist					
Kidney specialist					
Licensed clinical psychologist					
Licensed clinical social worker (LCSW)					
Licensed marriage and family therapist (LMFT)					
Lung specialist					
Neurologist					
Orthopedic specialist					
Psychiatric/mental health nurse practitioner (PMHNP)					
Psychiatrist					
Other (please be specific): _____					

2. Are you currently receiving any of the following services? ☐ Yes ☐ No If yes, please provide the applicable information below.

Services	Facility	Company	Provider name	Provider address	Phone no.
Applied behavior analysis (ABA)					
Clinical laboratory					
Dialysis					
Home therapy					
Intensive outpatient					
IV medication/chemotherapy					
Medical equipment					
Medication assisted treatment					
Medication management for a behavioral health condition					
Occupational therapy					
Organ or stem cell/bone marrow transplant					
Outpatient electroconvulsive therapy					
Oxygen					
Partial hospitalization					
Physical therapy					
Psychological testing					
Radiation therapy					
Rehab treatment					
Residential care					
Speech therapy					
Transcranial magnetic stimulation					
Other (please be specific) _____					

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No If yes, please provide the applicable information below.

Date scheduled (MM/DD/YYYY)	Type of surgery/procedure	
Name of physician performing surgery/procedure	Physician phone no.	Hospital/facility name

4. Requested start date for transition of care/continuity of care

Date (MM/DD/YYYY)

5. Other needs

Signature required

I authorize Anthem Blue Cross to leave confidential information on my voicemail at the number(s) provided on the form above.
Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do NOT leave confidential information on my voicemail

Signature of patient if age 18 or over **X**	Printed name	Date (MM/DD/YYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MM/DD/YYYY)

Continuity/Transition of Care Request Form
Authorized Disclosure Form
California

Anthem

Patient information

Patient last name	First name	M.I.	Date of birth (MM/DD/YYYY)

Authorization — Signature required

I, _____ (patient's name) hereby authorize my provider to give the Anthem Blue Cross reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that, with the exception of behavioral health services, the Anthem Blue Cross reviewing unit 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 the Anthem Blue Cross reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested transition assistance and need their cooperation.

Unless I specify otherwise on this form, I intend this authorized disclosure to include, if applicable, all substance use disorder records maintained by my provider about me pertaining to my current course of treatment and relevant to the transition assistance. I understand that my substance use disorder records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over **X**	Printed name	Date (MM/DD/YYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MM/DD/YYYY)