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Request for Continuity of Care Services for Established Members and New Enrollees

Criteria must be met:

- Member must have had care prior to the provider contract termination date or plan enrollment date with current ongoing care.
- Limited request time: Member may request continuity of care for up to **180 days** after provider contract termination or plan enrollment date.

Subscriber Information	Patient Information
Subscriber's Name and Address:	Member's Name and Address (If different):
Date of Birth:	Date of Birth:
Home Phone Number:	Subscriber ID:
Cell Phone Number:	Relationship to Subscriber:
Provider Information	**Provider Information**
Requesting Provider First & Last Name:	Requesting Provider First & Last Name:
Provider Specialty:	Provider Specialty:
Provider Address:	Provider Address:
Provider Phone: Provider Fax:	Provider Phone: Provider Fax:
Condition or diagnosis being treated:	Condition or diagnosis being treated:
Original start date with provider:	Original start date with provider:
Last office visit/treatment:	Last office visit/treatment:
Next appointment/treatment:	Next appointment/treatment:

To return this form by mail: **Blue Shield of California Attn: Continuity of Care Team,** **P.O. Box 629005, El Dorado Hills, Ca 95762**	**To return this form by fax: (855) 895-3506**

Revised: 10/10/2014 Effective: 10/10/2014

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Requesting Provider First & Last Name:	Requesting Provider First & Last Name:
Provider Specialty:	Provider Specialty:
Provider Address:	Provider Address:
Provider Phone: Provider Fax:	Provider Phone: Provider Fax:
Condition or diagnosis being treated:	Condition or diagnosis being treated:
Original start date with provider:	Original start date with provider:
Last office visit/treatment:	Last office visit/treatment:
Next appointment/treatment:	Next appointment/treatment:
Medical Information	

If pregnant, what is the expected delivery date?
Name of delivering hospital:
Name of OB/GYN:
Is member currently hospitalized? Circle Yes or No
Is member currently receiving home health care or hospice? Circle Yes or No
Name of home health care provider or hospice: Phone Number:
Does the member have a terminal condition? Circle Yes or No

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Additional information to be considered

Please list any additional information to be considered:

Member certification, authorization and signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize a physician, healthcare facility, and other provider of health care, insurance carrier, hospital, or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness, which this patient received at any time. This information is collected to evaluate and process this request.

Name of member responding:

Member signature:

Phone number where we may reach you:

For communication by email, please include your email address:

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