



CONTINUITY OF CARE REQUEST

To be Reviewed, Completed and Signed by Both the Physician and Member:

Continuity of care of health care services is approved by Blue Cross and Blue Shield of Louisiana or its subsidiary HMO Louisiana, Inc. (collectively referred to herein as “BCBSLA”) under special circumstances to allow members to continue receiving health care services from a non-network physician, or other health care practitioner, (collectively referred to herein as “physician”) for a specified duration of time.

In order to qualify for continuity of care benefits for health care services, the member must be either:

- 1) Diagnosed as being in a high-risk pregnancy or is past the 24th week of pregnancy. If so, the patient/member shall be allowed to continue receiving covered health care services, subject to the physician’s consent, through delivery and postpartum care related to the pregnancy and delivery, or
- 2) Diagnosed with a life-threatening illness. If so, the member shall be allowed to continue receiving covered health care services, subject to the physicians consent, until the course of treatment is completed, not to exceed three (3) months from the effective date of the qualifying event. “Life-threatening illness" means a severe, serious, or acute condition for which death is probable.

If the physician advises BCBSLA that the member meets either of the above criteria, BCBSLA may approve continuity of care of health care services. The right to receive continuity of care shall not apply when:

- 1) The physician’s termination is due to suspension or revocation of the physician’s license to practice in Louisiana or for another documented reason related to quality of care.
- 2) The member chooses to change physicians.
- 3) The member moves out of the geographic service area of the physician or health insurance issuer.
- 4) The member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

The member should discuss this continuity of care request form with his/her physician, and if the member’s physician thinks that continuity of care service is indicated, ask the physician to complete this form. The member and physician will need to sign this Continuity of Care Request Form and complete/submit the entire packet of requested information to Blue Cross and Blue Shield of Louisiana at: Blue Cross and Blue Shield of Louisiana, 5525 Reitz Ave., Baton Rouge, LA 70809, Attention: Care Management Services or may fax it to: 1-800-267-6548. Upon receipt, BCBSLA will review the information and notify the physician and the member of its decision to approve or deny continuity of care benefits.

To be Completed and Signed by the Physician:

Member Name _____

Date of Birth _____

Address _____

BCBSLA Member ID #: _____

Subscriber

Spouse

Dependent

Medical Condition for Continuity of Care Consideration

If Pregnancy, Give Due Date _____

Name of Physician _____ Phone Number _____

Address _____

Diagnosis (also give ICD-9 code) _____

Member’s Condition and Current Treatment Plan. Please include the anticipated length of time the continuity of care services are needed and any narratives or copies of medical records that will facilitate the evaluation process for your patient:

Please list other Physicians/Providers who are currently involved in caring for your patient:

I understand and agree to all of the terms and conditions. As the physician, I understand that should BCBSLA approve the continuity of care service request, BCBSLA will continue to pay me under the same terms and conditions under the physician agreement that was in effect prior to the qualifying event. In addition, I agree to accept the BCBSLA benefit payment, plus the member’s deductible, coinsurance and/or copayment, if applicable, for any covered services as payment in full and not bill the patient/member for any amount in excess of the BCBSLA professional allowance/allowable charge for covered services. Furthermore, I agree to follow BCBSLA’s utilization management and quality management policies and procedures for the applicable period in which the member is receiving continuity of care services.

Physician Signature _____ Date _____

I understand and agree to the terms and conditions. Each case will be considered individually, and approval is only for treatment of the specific health condition. All other treatment must be by providers in the member’s network to be eligible for contract benefits or higher level benefits, depending upon the terms and conditions of the member’s contract/certificate. Benefits are subject to the contractual limitations and exclusions set forth in the member’s contract/certificate. Any approval of continuity of care does not extend the contractual benefits in any way except to provide in-network level of benefits for a non-network provider for a temporary time period.

Member Signature _____ Date _____