

Do you want to continue receiving care from your doctor? Request for Benefits for Continuity of Care

Blue Cross and Blue Shield of Louisiana | HMO Louisiana, Inc.

What Is the Purpose of This Form?

At Blue Cross and Blue Shield of Louisiana or our subsidiary HMO Louisiana, Inc., we understand that sometimes doctors or other providers leave our networks while they are still treating some of our members. In certain cases, we allow members to have benefits to continue receiving services from their doctors or providers who are no longer in the network (an out-of-network provider).

You may have the right to continue to go to an out-of-network provider for a limited time. If approved, you could see that provider until the course of treatment is complete or 90 days after we notified you the provider is leaving the network, whichever comes first.

With your provider's help, fill out the *Request for Benefits for Continuity of Care* to ask us to consider your case. Once you send us your completed form, we will carefully review your case. After we reach a decision, we will notify both you and your provider.

Under What Conditions Can You Qualify for Benefits to Continue Care?

To qualify for benefits to continue care, you must be:

- **Undergoing a course of treatment for a serious and complex condition;** or
- **In the hospital or under inpatient care;** or
- **Scheduled for a non-elective surgery or procedure by the provider or in postoperative care;** or
- **Pregnant and undergoing a course of treatment for the pregnancy;** or
- **Terminally ill, which means your life expectancy is 6 months or sooner, and undergoing care for the terminal illness from the provider.**

When Will We Deny Benefits to Continue Care?

If your provider tells us that you meet any of the criteria listed, we may approve benefits for you to continue care with that provider.

But we will not approve benefits to continue care if:

- Your provider was terminated from the network because your provider's license to practice in Louisiana was suspended or revoked or for another documented reason related to quality of care; or
- Your provider was terminated from the network because of fraud; or
- You choose to change providers; or
- You move out of our geographic service area; or
- You do not meet the health conditions listed on this form to qualify for benefits to continue care from an out-of-network provider.

Still have questions?

Call us. We will be happy to help you.

Call Care Management at: 1-800-317-2299

Request for Benefits for Continuity of Care

Blue Cross and Blue Shield of Louisiana | HMO Louisiana, Inc.

If you are a member of Blue Cross and Blue Shield of Louisiana or our subsidiary HMO Louisiana, Inc., and you want to continue care with your doctor even though your doctor is no longer in our network, fill out Part 1 of this form. Then give the form to your doctor or provider to fill out Part 2 before you send it to us.

Part 1: Information for You, the Member

Your name
As shown on your Blue Cross ID card

Your mailing address

Street

City

State

ZIP code

Your date of birth

___ / ___ / ___
MM / DD / YYYY

Your Blue Cross ID number
As shown on your ID card

Are you ...

- The Subscriber?
 A Spouse?
 A Dependent?

Read this and sign below:

I understand and agree to the terms described in this form.

I know that Blue Cross considers each case individually, and that this request is only to treat the specific health condition or to obtain the specific service explained in this form.

Usually, to receive benefits according to my contract, I must go to doctors or providers in my network. My contract explains any limitations or exclusions of my plan.

Any approval you may give me to continue care with my doctor or provider is temporary. If you approve my request, it will last for up to 90 days. You are only providing network level of benefits so I can continue to go to my doctor or provider who is no longer in the network for a specific health condition or service. You are not extending benefits in my contract for any other reason or in any other manner.

Your signature

□

Today's date

___ / ___ / ___
MM / DD / YYYY

Part 2: Information for Your Doctor or Provider

Doctor's or Provider's name

Doctor's or Provider's mailing address

Street

City

State

ZIP code

Doctor's or Provider's phone number

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What is your patient's medical condition?

Is the patient pregnant?

No

Yes. Due date: ___ / ___ / ___

MM / DD / YYYY

<p>What is the diagnosis?</p>		
<p>What is the patient's current treatment plan?</p> <p>Include any narratives or copies of medical records that will help us evaluate this case.</p>		
<p>ICD-10 code?</p>		
<p>How long do you estimate that the patient needs your services?</p>		
<p>Are other providers now involved in your patient's care?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes. List them</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>Read this and sign below:</p>	<p>I understand and agree to the terms described in this form.</p> <p>I understand that if Blue Cross approves this request, you will continue to pay me under the same terms and conditions of the physician agreement that was in effect before the qualifying event occurred.</p> <p>Also, for any covered services, I will accept your payment, plus the member's deductible, coinsurance and copayment, if they apply. I will not bill the patient more than the allowable charge for covered services.</p> <p>I will follow Blue Cross' utilization management and quality management policies and procedures for the period during which the patient receives continuity of care services.</p>	
<p>My signature</p>	<p>□</p>	<p>Today's date ____/____/____</p> <p>MM / DD / YYYY</p>

After the form is complete, send it to us, along with any other information we requested.

Fax it to us at: **1-800-267-6548**

Mail it to us at: **Care Management Services**
Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809