Continuity of Care Request Form

Employer Name:

Member Name: **Member ID# (from ID card):**

Patient Name: **Telephone Number: ( )**

Continuity of Care allows you to continue receiving coverage from a non-network provider for an ongoing special condition at the network benefit level when your provider is no longer consider a network provider. If your provider leaves the network and they are currently treating you for a condition that meets the Plan's continuity of care criteria, you may be eligible for continuity of care for up to 90 days. Continuation of care will be considered when the member is:

A. undergoing a course of treatment for a '*serious and complex condition'* from the provider or facility;
B. undergoing a course of institutional or inpatient care from the provider or facility;
C. scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
D. pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
E. determined to be terminally ill (determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

'Serious and complex condition' means, (a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, a condition that is— life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

You must notify the plan of the need for continuity of care by completing and mailing this form to Interactive Medical Systems within 30 days of receipt at: PO Box 1349, Wake Forest, NC 27588

If you received a notification of provider term from Interactive Medical Systems, what is the date of the letter? _________

Indicate below what situations apply to the member requesting Continuity of Care:

- ☐ I am being actively treated for a terminal illness or serious and complex condition
- ☐ I have an existing precertification for upcoming medical services. Expected date of services _____________
- ☐ I am in my 2nd or 3rd trimester of pregnancy or receiving postpartum care. Expected due date ___________
- ☐ I am being treated or expect (within 90 days of effective date) to be treated inpatient
- ☐ I am currently receiving outpatient care or home care services on a long-term basis for a chronic ailment

Describe the medical condition for which you are applying for Continuity of Care, include any scheduled dates of service:

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Name of Physician/Inpatient Facility_________________________________ Phone # (_____)____________

Physician/Facilities' Address____

You will receive a reply letter advising if Continuity of Care is approved or denied. If approved, coverage under the Plan is provided under the same terms and conditions as would have applied and with respect to such items and services as would have been covered had such termination of network status not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient for up to 90 days.

____ ____________________
Signature of Patient or Personal Representative Date

____ ____________________
Name of Patient or Personal Representative Description of Personal Representative's Authority

Interactive Medical Systems **Phone: 919-877-9933** **Fax: 919-562-0023**