**Continuity of Care Request Form**

Complete and submit a Continuity of Care Form if you are currently receiving ongoing care or if you have services scheduled. Please do not complete and submit the form if you are not currently receiving ongoing care or if you do not have upcoming services scheduled.

You, your current physician, or a member of your physician’s staff may complete and submit the form. Please be sure to include the name of your physician or medical group on the form. Please mail the completed form to the address provided at the bottom of this form.

Please complete and submit a Continuity of Care Request Form if any of the circumstances listed below apply: You are currently receiving or are scheduled to receive any of the following:

* Prenatal/obstetrical care
* Chemotherapy
* Radiation therapy
* Physical/occupational/speech therapy
* Elective surgery
* Ongoing treatment for an acute inpatient stay
* Discharge planning after an acute inpatient stay, even if your previous health insurance carrier is still following your care
* Dialysis
* Home health care
* Hospice care
* Home IV therapy
* Inpatient rehabilitation
* Durable medical equipment
* Supplies

Instructions

Complete this form only if you are receiving ongoing care, or are scheduled to receive care, from a provider that does not participate in your participating network. Please complete a separate form for each covered family member who needs to have care transitioned to another provider.

Member Information

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name | First Name | M.I | Member ID Number |
| Member Employer Name |  | | |

Patient Information

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name | First Name | M.I | Date of Birth (MMDDYYY) |
| Preferred Phone Number  Home  Cell  Work | | Secondary Phone Number  Home  Cell  Work | |
| Current Primary Care Physician/Attending Physician | | New Primary Care Physician/Attending Physician | |
| Provide the name of your doctor or hospital that is nonparticipating in the Cigna network | | | |
| Diagnosis (include pertinent history and physical findings) | | | |

Medical Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have an appointment to see a specialist within the next six months?  Yes  No If yes, please provide the applicable information below. | | | | |
| Type | Physician name (last, first) and Physician phone no. | | Physician Address | Date of next office visit and reason |
| Heart specialist | Name: | |  | Date: |
| Phone: | | Reason: |
| Lung specialist | Name: | |  | Date: |
| Phone: | | Reason: |
| Blood or cancer specialist | Name: | |  | Date: |
| Phone: | | Reason: |
| Neurologist | Name: | |  | Date: |
| Phone: | | Reason: |
| Infectious disease specialist | Name: | |  | Date: |
| Phone: | | Reason: |
| Kidney specialist | Name: | |  | Date: |
| Phone: | | Reason: |
| Surgeon | Name: | |  | Date: |
| Phone: | | Reason: |
| Other (indicate provider type) | Name: | |  | Date: |
| Phone: | | Reason: |
| Obstetrician for pregnancy  Due Date: | Name: | |  | Date: |
| Phone: | | Reason: |
| Hospital for Delivery: | | | |
| Are you currently receiving any of the following services? | | | | |
| Oxygen  Yes  No | | Company: | | |
| IV medication  Yes  No | | Company: | | |
| Home Therapy  Yes  No | | Company: | | |
| Rehab Treatment  Yes  No | | Company: | | |
| Medical Equipment  Yes  No | | Company: | | |
| Dialysis  Yes  No | | Company: | | |
| Laboratory  Yes  No | | Company: | | |
| Physical Therapy  Yes  No | | Company: | | |
| Occupational Therapy  Yes  No | | Company: | | |
| Speech Therapy  Yes  No | | Company: | | |
| Radiation Therapy  Yes  No | | Company: | | |
| Other, please be specific  Yes  No | | Company: | | |
| Do you have any hospitalizations, surgeries or procedures scheduled?  Yes  No | | | | |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Surgery/Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name/phone no. of physician performing surgery/procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital/Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Other needs/comments:  Yes  No If yes, please detail below | | | | |
|  | | | | |

|  |  |  |
| --- | --- | --- |
| Signature Required | | |
| I hereby authorize my provider to give my PPO Network 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 Continuity of Care. I understand that my PPO Network 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 continuity/transition of care and need their cooperation. 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 | Printed Name | Date (MMDDYY) |
| Signature of parent or guardian if patient is under age 18 | Printed Name | Date (MMDDYY) |

Please mail the completed form to:

Harrison Electrical Workers Trust – PD00

PO BOX 1618

San Ramon, CA 94583