Continuation of Care Form

(To be used when a provider is no longer contracted with Anthem BCBS Network)

Our goal is to provide benefits for continuity of care for any new member of Anthem Blue Cross and Blue Shield who is receiving prenatal care or is in ***active*** *treatment ,for an acute or chronic condition with a* provider who has left the Anthem Blue Cross and Blue Shield Network. Visits through the current period of active treatment **or** up to 90 days, depending on the care needs and circumstances will be approved. If the member chooses to continue her prenatal care with an out of network provider, the visits may be approved if the member is receiving prenatal care during the second or third trimester of pregnancy and will continue through the provision of post-partum care directly related to the delivery.

If you or any covered family member are receiving care of this kind from a non participating provider, please complete this form. Information provided will be kept confidential by Anthem Blue Cross and Blue Shield and will only be used in accordance with applicable privacy laws. Anthem Blue Cross and Blue Shield may share this information with your primary care provider (PCP) and/or specialist and may be in contact with you to facilitate continuity or continuation of care.

Subscriber/Employer Info:
Subscriber Name: ________________________________ Coverage Effective Date:___________
Group Number: __________________________
Employer Name: ____
Type of Coverage, i.e., (HMO, PPO) _____________________

Patient Info:
Patient Name: ____ Patient DOB: _______________
Patient ID#________________ Home Telephone #:_________________ Work Telephone#_________________________
Patient Address: ____
Best time to contact:__________________________

Provider Info Primary Care Provider (PCP): ____
PCP Address: ____
PCP Telephone #: ____

1) Specialist Name: ____ Telephone #: ___________________
Specialist Address: ____

2) Specialist Name: _____________________________________Telephone #_______________________
Specialist Address: ____

Services Requested for Transitional Care:

___ Ambulatory/Same Day Surgery ___ Durable Medical Equipment ___ GYN/infertility
___ Hospice Care ___ Inpatient Care (after surgery) ___ Mental Health
___ OB _____ Date of Delivery ___ Oncology ___ Out of Network Care
___ Outpatient Rehab (physical therapy, occupational therapy, speech therapy)
___ Pediatrics ___ Surgery/Treatment Type of Surgery________________________

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___ Transplant ___ Other: ____
___ Chronic/Long Term Illness, name of illness____

Diagnosis:____

Brief Description of active treatment being received:

____

____

Are you working with a nurse case manager with your Health Plan at this time? Yes/No
If yes, what health care needs are being addressed?____

Would you like to be contacted by the Case Management Department at Anthem to discuss your health care needs? Yes/No

Signature of Subscriber/Guardian/Parent of the Patient: ____

Date: _______________

Please mail completed form to: **Denise O'Reardon**
CT Carpenters Health Fund
10 Broadway, Hamden, CT 06518

(or) fax to: **Denise O'Reardon at: 203-288-3235**

Note: For questions on filling out the form or if you need assistance on filling out the form please contact the number on the back of your ID card.

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