

Request for Continuity of Care



WHAT IS CONTINUITY OF CARE?

Continuity of Care allows Blue Cross Blue Shield of North Dakota (BCBSND) members to continue receiving covered health care services for specific medical conditions from a non-participating or out-of-network provider. Services are provided for a specific duration of time at the benefit level associated with participating, in-network providers. Continuity of Care eligibility is based upon the events listed in SECTION 1 of this form.

Please discuss this form with your provider and ask them to complete SECTION 3. Both you and your provider are required to sign this form before submitting the requested information to BCBSND. BCBSND will review your information and notify you of our decision to approve or deny your Request for Continuity of Care.

HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUITY OF CARE BENEFITS?

1. Read and complete SECTION 1
2. If you answer **YES** to *any question*, you may be eligible for Continuity of Care benefits

If you answer **NO** to all the questions, you are not eligible for Continuity of Care benefits. You do not need to have your provider complete Section 3 or submit this form to BCBSND.
3. If you need assistance finding a new participating or in-network provider, please visit www.bcbsnd.com or call the Member Services telephone number located on the back your ID card.

THE REQUEST PROCESS

1. If you answer **YES** to any question in SECTION 1, please complete SECTION 2.
2. In addition, you need to ask your health care provider to complete SECTION 3 of this form. If you are receiving care from more than one health care provider, each health care provider must individually complete SECTION 3.
3. Mail or fax the completed form and related medical records, to:

Blue Cross Blue Shield of North Dakota
Attn: Continuity of Care – Utilization Management
4510 13th Avenue South
Fargo, North Dakota 58121-0001
FAX: (701) 277-2253

SECTION 1 – TO BE COMPLETED BY MEMBER

- 1. Are you at least 3 months pregnant or did you deliver less than 6 weeks ago? Yes No
- 2. Are you pregnant? If yes, has your doctor told you this is a high risk pregnancy? Yes No
- 3. Are you currently getting non-surgical treatment (radiation, chemotherapy) for cancer? Yes No
If yes, please provide date of last treatment: _____
- 4. Are you currently getting surgical cancer treatment? Yes No
If yes, please provide date of last surgery: _____
- 5. Are you getting active treatment for Human Immunodeficiency Virus (HIV) or symptomatic Acquired Immunodeficiency Syndrome (AIDS)? Yes No
If yes, please provide date of last treatment: _____
- 6. Are you getting active treatment for severe or end-stage kidney disease or dialysis? Yes No
If yes, please provide date of last treatment: _____
- 7. Have you received a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ? Yes No
If yes, please provide date of last treatment: _____
- 8. Are you currently getting inpatient services at a facility? Yes No
If yes, please provide name of facility and date of admission: _____
- 9. Are you currently getting outpatient or inpatient mental health or substance abuse services by a licensed mental health provider? Yes No
If yes, please provide the name of your provider and date last seen: _____
- 10. Are you currently receiving treatment for a serious acute condition or other life-threatening condition not described above? Yes No
If yes, please provide the name of your provider, date last seen and detailed description of your condition: _____

For consideration of mental health and substance abuse services, please call the Member Services telephone number on the back of your ID card.

SECTION 2 – TO BE COMPLETED BY MEMBER.

Please complete all the fields below.

Member Name		Date Of Birth (MM/DD/YYYY)	
Address	City	State	Zip Code
BCBSND Member Id Number	Home Phone Number	Work Phone Number	
Member's Relationship To Subscriber (E.g. Spouse, Dependent, Self)			

AUTHORIZATION TO RELEASE RECORDS

I authorize all health care providers to provide Blue Cross Blue Shield of North Dakota (BCBSND) information concerning medical care, advice, treatment, or supplies for the member named above. This information will be used to determine the member's eligibility for Continuity of Care benefits under the plan.

Member's Signature/Parent or Guardian's Signature if Applicant is A Minor

Date

SECTION 3 – TO BE COMPLETED BY HEALTH CARE PROVIDER CURRENTLY TREATING CONDITION.

This section of the form only needs to be reviewed and filled out by your provider IF you answered YES to one of the conditions in Section 1. If you answered NO to all of the conditions in Section 1, your provider does not need to fill out this form.

Please fill out and ensure the entire form is completed before submitting to BCBSND.

Provider Name		Provider NPI	
Phone Number		Fax Number	
Address	City	State	Zip Code
Date Of Last Visit	Next Scheduled Appointment (MM/DD/YYYY)	Frequency Of Visits	
Diagnosis			
Expected Length of Treatment	If Maternity, Expected Date of Delivery (MM/DD/YYYY)	Facility Name	
Current Treatment/Comments			

Provider's Signature

Date