MASSACHUSETTS

CONTINUITY/TRANSITION OF CARE REQUEST FORM

Use the attached form to submit continuity/transition of care requests within 90 days of your transition needs.

We offer eligible members continued coverage for active treatment that was authorized by their previous health plan. When coverage is approved, you may complete your course of treatment if your treating provider is in our network, or you'll receive temporary coverage for up to 90 days while you transition to an in-network provider.

YOU MAY BE ELIGIBLE IF:*

You're a new Blue Cross Blue Shield of Massachusetts member, and your treating provider that was in your former plan's network isn't part of our network.

Your continuity of care is at risk for reasons beyond your control, such as when your provider leaves your plan's network.

YOU CAN SUBMIT A REQUEST FOR TEMPORARY CONTINUED COVERAGE IF YOU:

- Are in active course of treatment for an acute medical condition; a serious, chronic condition; cancer or chemotherapy; allergies; or a mental health condition
- Are pregnant, regardless of trimester
- Have a terminal illness
- Have a surgery or other procedure that has been authorized under your previous plan and is scheduled to occur within 90 days of your new plan's effective date
- Are enrolled in a cardiac rehab program that's already in progress
- Have established care with a specialist treating your acute or serious chronic condition
- Are newly enrolled in a plan with a Blue Distinction® Specialty Care feature that encourages selection of Blue Distinction designated providers and facilities for certain types of specialty care

How to submit your request

Complete the attached form, then submit it to us by fax or mail using the address listed at the bottom of the form. Allow two weeks for us to complete the review.

*Commercial members who have elected to make changes in their coverage that cause the provider or facility to be out of network aren't eligible for this request.

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NEED TO FIND A PROVIDER?

If you need ongoing care for a chronic condition but aren't in an active course of treatment, visit an in-network provider for covered care that meets your needs. Use our **Find a Doctor & Estimate Costs** tool to find the right provider for you.

To start searching, sign in to MyBlue at **bluecrossma.org**, then select **Find a Doctor**.

CONTINUITY/TRANSITION OF CARE REQUEST FORM

Once we've received your medical records and completed our review, we'll contact you and your provider with the results. Allow two weeks for us to complete this review.

Request (check one):

❑ **Transition of care**

Who should apply: New Blue Cross members who are receiving ongoing treatment covered by their previous plan or from a provider who isn't part of the Blue Cross network

When approved: You'll receive temporary, uninterrupted coverage for up to 90 days from your plan's effective date.

❑ **Continuity of care – general**

Who should apply: Members who are receiving ongoing treatment from a provider who has recently left the Blue Cross network

When approved: You'll receive temporary, uninterrupted coverage for up to 90 days.

❑ **Continuity of care – for members enrolled in a tiered plan**

Who should apply: Members using a tiered provider network, who are receiving ongoing treatment from a provider who has moved to a higher cost-sharing tier

When approved: You'll receive temporary, uninterrupted coverage at a lower-cost tier for up to 90 days.

❑ **Continuity of care – for members enrolled in a plan with a Blue Distinction Specialty Care feature**

Who should apply: Members whose new Blue Cross plan includes a Blue Distinction Specialty Care feature and are receiving ongoing treatment from a provider not currently recognized as a Blue Distinction designated provider

When approved: You'll receive temporary, uninterrupted coverage at a lower-cost tier for a defined period of time. Blue Distinction specialty service of bariatric surgery or transplants will receive up to 180 days coverage, while other specialties will receive up to 90 days of coverage.

Note: If we already processed claims as if the provider were out of network, and we paid you directly, we may need to adjust those claims. Once that happens, we may ask you to refund payment that we previously issued to you.

Subscriber information

Last name	First name	Middle initial	Date of birth _____

Address – number and street	City	State	ZIP code

Plan effective date	Blue Cross member ID #

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Patient information (if different from subscriber)

The primary member of a health plan is the subscriber. If the subscriber and patient are the same person, there's no need to complete the patient information section.

Last name	First name	Middle initial	Date of birth _____ _____ _____

Address (if different than subscriber)	City	State	ZIP Code

Other information

Preferred phone #	❑ Home phone #	❑ Work phone #	❑ Cell phone #

Does the patient have a primary care provider (PCP)? ❑ Yes ❑ No
If yes, list your PCP's name:

Do you give us permission to contact this PCP with the results of this request? ❑ Yes ❑ No

PCP phone #:

TREATMENT INFORMATION

In the following fields, list information for the patient and treating provider(s), and describe the care plan for the treatment(s) that you would like to be considered in this request. You may include information for more than one treatment in this request.

Treatment #1

Provider name	Specialty

Provider address	City	State	ZIP code

Provider phone #	NPI #	Provider date of termination (if applicable) _____ _____ _____

Date of next appointment _____ _____ _____	Length of treatment	Expected # of visits	Date treatment began _____ _____ _____	Date of last appointment _____ _____ _____

Treatment plan description

Facility name (if applicable)

Facility address	City	State	ZIP code

Facility phone #	NPI #	Facility date of termination (if applicable) _____ _____ _____

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Treatment #2 (if applicable)

Provider name			Specialty		
Provider address			City	State	ZIP code
Provider phone #	NPI #		Provider date of termination (if applicable) _____ _____ _____		
Date of next appointment _____ _____ _____	Length of treatment	Expected # of visits	Date treatment began _____ _____ _____	Date of last appointment _____ _____ _____	
Treatment plan description					
Facility name (if applicable)					
Facility address			City	State	ZIP code
Facility phone #	NPI #		Facility date of termination (if applicable) _____ _____ _____		

Treatment #3 (if applicable)

Provider name			Specialty		
Provider address			City	State	ZIP code
Provider phone #	NPI #		Provider date of termination (if applicable) _____ _____ _____		
Date of next appointment _____ _____ _____	Length of treatment	Expected # of visits	Date treatment began _____ _____ _____	Date of last appointment _____ _____ _____	
Treatment plan description					
Facility name (if applicable)					
Facility address			City	State	ZIP code
Facility phone #	NPI #		Facility date of termination (if applicable) _____ _____ _____		

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Member authorization

I hereby authorize the above provider to give the Blue Cross Blue Shield of Massachusetts Transition Assistance department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for continuity/transition of care. I understand that Blue Cross Blue Shield of Massachusetts Care Management may share information and discuss my care with my primary care provider/ medical group under my plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Blue Cross Blue Shield of Massachusetts to leave confidential information on my voicemail at the number(s) listed above, unless I specify otherwise below.

Check all that apply:

❑ Home	❑ Cell	❑ Work	❑ DO NOT leave confidential information on my voicemail.

Signature of patient if 18 or over	**Date of birth** _____ _____ _____
Signature of parent or guardian if patient is under 18	**Date** _____ _____ _____

Complete this form in its entirety, and mail or fax it to the address or appropriate number.

Mail to: Blue Cross and Blue Shield of Massachusetts
Attn: Health and Medical Management,
Clinical Intake Transition of Care
One Enterprise Drive, M/S 02/05
Quincy, MA 02171-2126

Fax to: 1-888-282-0780
(Medical and surgical requests)

Fax to: 1-888-641-5199
(Mental health requests)

Questions?

If you have questions about completing this form, call Member Service at the number on your ID card.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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