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 temporary, continued coverage, when undergoing active treatment from a provider who is no longer part of your plan's network. If coverage is approved, you can complete your course of treatment or transfer safely to an in-network provider or facility.

YOU MAY BE ELIGIBLE IF:*

You're a new Blue Cross Blue Shield of Massachusetts member, and your plan's treating provider isn't part of your network

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

WHEN YOU SHOULD REQUEST CONTINUITY/TRANSITION OF CARE

You may 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

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 & Estimate Costs**.

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.

*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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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 from a provider who isn't part of the Blue Cross network

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

❑ **Continuity of Care**

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

If approved: You'll receive temporary, uninterrupted coverage for a defined period of time.

❑ **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 the highest cost-sharing tier

If approved: You'll receive temporary, uninterrupted coverage at a lower-cost tier for a defined period of time.

❑ **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

If 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 #**		

Patient Information

Last Name	First Name	Middle Initial	Date of Birth ____/____/____
Address (if different than subscriber)	**City**	**State**	**ZIP Code**

Preferred Contact # ❑ Home Phone # ❑ Work Phone # ❑ Cell Phone #

Do you have a primary care provider (PCP)? ❑ **Yes** ❑ **No**
If yes, list your PCP's name:

Do you give us permission to contact your PCP with the results of this request? ❑ **Yes** ❑ **No**
PCP phone #:

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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 No. 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 #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 No. 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 #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 No. 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)**	_____/_____/_____

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.

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