Continuity of Care Form

Continuity of care will be issued under special circumstances to allow members to continue treatment with a non-plan provider(s) for a period of time following the date of enrollment. Please complete this form if you or one of your dependents is currently being treated by a non-plan provider. One form must be submitted for each provider. The following is a list of services that may or may NOT be considered for continuity of care.

- Unstable or serious medical problems that require **a limited course of treatment or follow-up care**, such as those listed below may be eligible for continuity of care:
  - Pregnancy or high risk
  - Recent heart attack
  - Newly diagnosed cancer
  - Other ongoing acute care
- Members with special needs that require treatments to maintain level of function will be reviewed on a case by case basis.
- Examples of chronic medical conditions which are **NOT** typically eligible for continuity of care include:
  - Arthritis
  - Hypertension
  - Diabetes
  - Asthma and allergies
- If the treating physician is in the Memorial Hermann Health Plan network, do **NOT** complete this form. Please refer to the physician listing on https://healthplan.memorialhermann.org/ or call customer service at (855) 645-8448.
- If you have any questions about continuity care or need help completing this form, please call the Memorial Hermann Health Insurance Company Medical Management Department at: (855) 645-8448.
- Please ask your treating physician to fax any clinical information related to this continuity of care request to the Memorial Hermann Health Plan Medical Management Department at (713) 338-6494.

EMPLOYEE/SUBCRIBER INFORMATION

Employee's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Telephone Number: _____

Effective Date of Coverage: _____

Employer Name: _____

CONTINUITY OF CARE INFORMATION

Member Information

Member's Name: _____ DOB: _____

Relationship to Employee: _____

Condition being treated:

_____

How long has the doctor been treating the member for the current condition?
Years_____ Months _____

How long is the treatment expected to continue?
Years_____ Months _____

What is the nature of the treatment?
_____

Was the member hospitalized recently for this condition? Yes No
Admission Date: _____

Did the patient have surgery? Yes No
What Type? _____
When? _____

If pregnancy-related, list initial visit date: _____ LMP: _____
Estimated Delivery Date: _____

Non-Contracted Provider Information

Name: _____ Tax ID or NPI#:_____

Street Address:
_____

City: _____ State: _____
Zip Code: _____

Telephone Number: _____

Specialty: _____

Hospital of facility where surgery, treatment, or delivery is scheduled or currently being provided:
_____
Telephone number of hospital or facility:
_____

AUTHORIZATION TO RELEASE INFORMATION PERSONAL HEALTH INFORMATION

I authorize _____
Provider's Name
to release to Memorial Hermann Health Plan Medical Management Department all information relating to past, present, and future health care examinations, conditions, and treatments for: _____

_____
(Brief Description of Medical Condition)

This information will be used to determine if services for the above provider for the stated condition may be covered on or after the effective date by Memorial Hermann Health Plan Medical Management Department. I understand that continuity of care is subject to contractual limitations and exclusions set forth in the subscriber contract. I also understand that Memorial Hermann Health Plan does not extend the contractual benefits in any way except to provide coverage for the non-plan provider for a temporary time period.

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature: _____ Date: _____
*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information

FOR OFFICE USE ONLY		
Approved	Denied	Explanations/limitations
_____ Medical Director/Designee		_____ Date

TO MEMBER/EMPLOYEE: Please complete this form and return it to the following address:

Memorial Hermann Health Plan
Medical Management Department
PO Box 19909
Houston, Texas 77224-1909
Fax to: (713) 338-6494