

## CONTINUITY OF CARE FORM

*In order to best facilitate your care, we need to ask you a couple of questions so that we can ensure that your care is not disrupted. Please fill out separate form for each family member if there is a need for transition.*

**FILL OUT FORM COMPLETELY – Do not leave any blanks.**

**PLEASE NOTE: THIS FORM ONLY NEEDS TO BE COMPLETED IF YOU ARE RECEIVING ONGOING CARE OR ARE SCHEDULED FOR CARE**

Subscriber Name: _____	Subscriber's ID Number: _____
Patient Name: _____	Patient's ID Number: _____
Best Number to be called during the day: _____	Home Phone Number: _____
Current Primary Care Provider: _____	New Primary Care Provider/Attending Physician: _____
Attending Physician: _____	Attending Physician: _____

1. Do you have an appointment to see a specialist within the next 6 Months?  Yes  No

	Physician Name (last, first)	Physician Phone #	Date of Office Visit
a.	Heart Specialist		
b.	Lung Specialist		
c.	Blood or Cancer Specialist		
d.	Neurologist		
e.	Infectious Disease		
f.	Kidney Specialist		
g.	Surgeon		
h.	<b>Other: Be Specific</b>		

2. Are you currently receiving any of the following services?

- |    |                   |     |    |         |       |
|----|-------------------|-----|----|---------|-------|
| a. | Oxygen            | Yes | No | Company | _____ |
| b. | IV Medication     | Yes | No | Company | _____ |
| c. | Home Therapies    | Yes | No | Company | _____ |
| d. | Rehab Treatment   | Yes | No | Company | _____ |
| e. | Medical Equipment | Yes | No | Company | _____ |
| f. | Dialysis          | Yes | No | Company | _____ |

3. Do you have any hospitalizations, surgeries or procedures scheduled? Yes  No

Date? \_\_\_\_\_ Name of Surgery? \_\_\_\_\_  
 \_\_\_\_\_ Physician Name/Phone (performing surgery) \_\_\_\_\_  
 Name/Location of Surgery: \_\_\_\_\_

4. Have you been in the hospital in the past six months or the emergency room within the past six months?

Yes  No  For What: \_\_\_\_\_  
 What Hospital? What dates of service? \_\_\_\_\_

5. Are you currently pregnant? Yes  No  Due Date: \_\_\_\_\_

Who is your OB Physician? \_\_\_\_\_

6. Other Needs/Comments: \_\_\_\_\_

**If you answered yes to any question, a nurse will be contacting you to coordinate your continuity of care, if appropriate.**

**Mail completed form to: Anthem Blue Cross and Blue Shield, HS0535, Denver, CO 80273 or Fax to: (303) 764-7030**



## Continuity of Care Form Reference Sheet

A Continuity of Care Form should be completed and submitted if you are currently receiving ongoing care or if you have services scheduled. **NOTE: Please do not complete and submit the form if you are NOT currently receiving ongoing care or if you do NOT have upcoming services scheduled.**

You, your current physician, or a member of your physician's staff may complete and submit the form. Please be sure to include the name of your new Primary Care Physician (PCP) or Primary Medical Group (PMG) on the form. If that information is omitted, we will call you and request that you select a PCP or PMG as soon as possible. Please fax the completed form to your local Medical Management Department fax number, which is located on the front of this form.

Complete and submit a Continuity of Care Form if any of the following circumstances apply:

**I. You currently need a referral to an in- or out-of-network specialist.**

**II. You are currently receiving or are scheduled to receive any of the following types of care and/or services:**

- ◆ Prenatal/obstetrical care
- ◆ Elective surgery
- ◆ Ongoing treatment for an acute inpatient stay
- ◆ Discharge planning after an acute inpatient stay, even if your previous health insurance carrier is still following your care
- ◆ Dialysis
- ◆ Home health care
- ◆ Hospice care
- ◆ Home IV therapy
- ◆ Inpatient rehabilitation
- ◆ Durable medical equipment
- ◆ Supplies

**III. Your medical condition includes any of the following:**

- ◆ You are medically impaired and unable to move without the aid of a mechanical device.
- ◆ You have limited ability to move from place to place.
- ◆ You experience hardship in travel, which threatens your safety or welfare.