Providence Health Plan | POWERED BY Collective Health

Continuity of Care and Transition of Care Request Form

When your in-network provider becomes out-of-network, you may request Continuity of Care or Transition of Care coverage if your medical condition prevents an immediate transfer to a network provider.

Continuity of Care applies when your current in-network provider leaves the medical network and becomes out-of-network.

Transition of Care applies when your health plan changes its medical network and your in-network provider is now considered out-of-network with the new medical network.

To qualify, you must meet the criteria[1] below:

A Continuing Care Patient is a patient who, with respect to a provider or facility—

- is undergoing a course of treatment for a serious and complex condition (as defined below) from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider or facility, including receipt of post-operative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1395x(dd)(3)(A) of title 42) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition is defined, with respect to a patient, as:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that—
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

You and your provider must complete this form and submit it to Collective Health within 30 days of the provider's network status change. **You must also include the relevant medical records in your request.** If you are requesting continuity of care/transition of care for more than one provider or condition, please complete one form for each provider/condition.

If approved, the covered services rendered by the approved provider will be covered at the in-network benefit level for 90 days from when your provider becomes out-of-network, or through the completion of the current active course of treatment, whichever is earlier.

Please complete all the fields and sign where indicated. Submit the form to Collective Health via
Online: send a secure message at my.collectivehealth.com;
Fax: 800.351.4301; or
Mail: If you would like to submit this form and medical records by mail, please send it in a security envelope to

ATTN: COC/TOC
Collective Health
1557 W Innovation Way, Suite 300
Lehi, UT 84043

[1] Criteria based on 29 USC § 1185g(b)(1)

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Patient Information	
Patient Name	Patient Date of Birth (mm/dd/yyyy)
Subscriber ID	Subscriber Name
Patient's Relationship to subscriber ◯ Self ◯ Spouse ◯ Domestic partner ◯ Child	
Is the patient covered by another health plan? ◯ Yes ◯ No *If yes, please provide the following information:*	
Policyholder Name	Policyholder ID
Policyholder Date of Birth	Group ID
Effective Date of Policy (mm/dd/yyyy)	Termination date of Policy (mm/dd/yyyy)
Name of Policy Carrier	

Authorization to release records:

I authorize the physicians and other healthcare professionals or facilities identified on the form below to provide Collective Health and its business partners information concerning medical care, advice, treatment or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition of Care/Continuity of Care benefits under the plan.

Patient's Signature — Date (mm/dd/yyyy)
(parent or guardian's signature if patient is a minor)

Care Information *This section must be complete by the healthcare professional.*	
Treating Provider Name	
Phone Number	Fax Number
National Provider Identifier (NPI)	Tax ID Number (TIN)
Address (include city, state, and zip)	
Facility Name	Facility Phone Number
Facility NPI	Facility TIN
Facility Address (include city, state, and zip)	
Date of Last Visit (mm/dd/yyyy)	Next Scheduled Appointment (mm/dd/yyyy)
Diagnosis	Frequency of Visits
Expected Length of Treatment	If Maternity: Expected Delivery Date (mm/dd/yyyy)

Please select **one**(1) applicable reason for requesting continuing care:

- ◯ Life-threatening condition
- ◯ Acute condition
- ◯ Transplant
- ◯ Inpatient/Confined
- ◯ Upcoming surgery
- ◯ Pregnancy
- ◯ Terminal illness
- ◯ Ongoing treatment

Is the treatment for an exacerbation of a previous injury or chronic condition?

◯ Yes ◯ No

Current Condition and Associated Treatment Plan (include statement and all relevant CPT codes) **Please also attach the patient's medical records.**

We understand you are not, or soon will not be, a participating provider in the patient's health plan's medical network. The patient is receiving treatment for the above medical condition from you and is seeking to continue coverage at the in-network benefit level.
If the patient is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the patient's plan, for the applicable time-frame, (2) upon request, share information regarding the patient's treatment, (3) if applicable, make referrals for services, including laboratory services to network providers, or ask for approval before referring a patient to an out-of-network provider, and (4) if applicable, request any required prior authorization before the services are rendered.

Please note the following:
For providers leaving the network: The terms and conditions of your participation agreement with the medical network will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Collective Health, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.
For providers that are out-of-network with the plan's new network: If the patient is eligible, coverage will be provided at the in-network benefit level. Payment will be consistent with the member's benefit plan. You agree to accept this payment along with any co-payment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Collective Health, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Healthcare Professional	Date (mm/dd/yyyy)