



**BlueCrossBlueShield
of North Carolina**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Continuity of Care Form

Patient Name _____ Date _____
Date of Birth _____ BCBSNC ID # _____
Address _____
Telephone Number (home) (____) _____ (work) (____) _____
Employer/Group Name _____

Continuity of Care is designed to assist members and eligible dependents in the continuation of their care from a provider who is no longer in-network/participating. To be eligible for continuity of care one of the following conditions must apply:

1. **Member has an acute illness**, which is a condition serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
2. **Member has a chronic illness or condition**, which is a disease or condition that is life- threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
3. **Member is terminally ill**, a medical prognosis that the individual's life expectancy is six months or less.
4. **Member is in the second or third trimester of pregnancy or completing postpartum care.**

Requests for Continuity of Care will be reviewed by a medical professional and will be based on the information provided on this form about specific medical conditions. You have 45 days to request Continuity of Care from the date on the provider termination letter you received, or 45 days from your date of enrollment with Blue Cross and Blue Shield of North Carolina (BCBSNC). Notification about eligibility for Continuity of Care will be sent after a decision is made. If a Continuity of Care request is approved, you may continue to see your current provider through the timeframe specified in your authorization. BCBSNC will assist members with finding an in-network/participating provider for any future services before the applicable transition period expires.

- If you are currently receiving care for covered mental health or substance abuse services, and you are enrolled in or enrolling in **Blue Care** please call **1-800-359-2422** to determine if Continuity of Care is applicable.
- If you are currently receiving care for covered mental health or substance abuse services, and you are enrolled in or enrolling in **Blue Options, Blue Options HRA or Blue Options HSA** call **1-800-672-7897** to determine if Continuity of Care is applicable.

If you are eligible for Continuity of Care, you must meet one of the conditions described in the list above.

1. Complete the applicable portions of this form below
2. Complete the Authorization For Release of Protected Health Information Form
3. Return both forms to:

**Blue Cross and Blue Shield of North Carolina
Care Management & Operations
Attn.: CoC Coordinator
PO Box 2291
Durham, North Carolina 27702 -2291**

**Or fax to us at:
Fax: 1- 800-228-0838**

For BCBSNC Use only:

**Authorization # _____
Date of Service _____
Number of Visits Approved _____
Reviewer's Initials _____**



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What is your medical condition? _____

If you received a notification of provider termination from BCBSNC, what is the date of the letter? _____

Please complete ONLY the sections below that apply to you or any dependents

1. Do you have an **existing certification or authorization** for medical services? If yes, please provide the following information.

Patient Name _____ Date of Birth _____
What services are you receiving? _____
Name of Physician _____ Phone # (____) _____
Physician's Address _____

2. Are you in your **2nd or 3rd trimester of pregnancy or receiving postpartum care** (greater than 12 weeks pregnant or delivered within the last two months)? If yes:

Patient Name _____ Date _____ of _____ Birth _____
Name of Physician _____ Phone # (____) _____
Physician's Address _____
Due Date _____ Hospital _____
Next Appointment Date _____

3. Are you being treated or expect (within 90 days of effective date) to be treated as an **inpatient (hospital, skilled nursing or rehabilitation facility)**? If yes:

Patient Name _____ Date of Birth _____
Name of Inpatient Facility _____
Anticipated Admission Date _____
Name of Physician _____ Phone # (____) _____
Physician's Address _____
Anticipated Treatment / Surgery _____

4. Are you receiving **outpatient care on a long-term basis** for conditions such as but not limited to cancer, kidney dialysis, asthma or other chronic ailments? If yes:

Patient Name _____ Date of Birth _____
What services are you receiving? _____
Where are you receiving the services? _____
Date of Scheduled Appointment(s) _____ Date of Last Service _____
Name of Primary Care Physician _____

5. Are you receiving **home care services**? If yes:

Patient Name _____ Date of Birth _____
What services are you receiving? _____
Name and address of agency rendering the service _____
Name of Primary Care Physician _____

6. Do you have **durable medical equipment** in the home, such as oxygen, a wheelchair, etc. that is currently being paid for by your medical benefit plan? If yes:

Patient Name _____ Date of Birth _____
List the equipment and rental agency _____
Name of Primary Care Physician _____

7. Is a physician or other health care provider actively seeing you? (**Actively = 4 or more times in the past 6 months Or 6 or more times in the past 12 months**) If yes, please provide the following information.

Patient Name _____ Date _____ of _____ Birth _____
What services _____ are _____ you _____ receiving? _____
Name of Physician _____
Phone # (____) _____
Physician's Address _____



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AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION
FOR CONTINUITY OF CARE

I authorize the use and disclosure of my protected health information as described below.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy or other medical caregiver that has treated me or provided medical services or supplies to me to disclose my protected health information to **Blue Cross and Blue Shield of North Carolina (“BCBSNC”)**.

The protected health information that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers.

I understand that BCBSNC will use and disclose my protected health information for the following purposes: **To coordinate continuity of medical care.**

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that BCBSNC will not condition the provision of health plan benefits on this authorization.

I understand that I may revoke this authorization at any time by sending a written notification addressed to: **Blue Cross and Blue Shield of North Carolina, Healthcare Management Operations, Attention: Continuity of Care Coordinator, P. O. Box 2291, Durham, NC 27702-2291**, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that BCBSNC already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in BCBSNC and, by law, BCBSNC has a right to contest the coverage.

This authorization expires 30 months from the date of signature.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative’s Authority

Return this Authorization Form to:
Blue Cross and Blue Shield of North Carolina
Care Management & Operations
Attn: CoC Coordinator
P. O. Box 2291
Durham, North Carolina 27702-2291
FAX: 1-800.228.0838

BCBSNC WILL PROVIDE PATIENT WITH A COPY OF THIS AUTHORIZATION



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Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina (“BCBSNC”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
 - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019**, **800-537-7697** (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.



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ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意: 如果您講廣東話或普通話, 您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY : 1-800-442-7028) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-206-4697 (TTY: 1- 800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુલ્ક ભાષા સહાય સે વાચામારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ : ប្រសិន បើ លោកអ្នក កនិ យាយជាភាសាខ្មែរ រ សេវាកម្ម ជំនួយ យន្តការ ភាសាមានផ្តល់ ឱ្យ អ្នកឱ្យបាន ឥតគិតថ្លៃ ។ សូម មេត្តា ទាក់ ទង ឯកសារ: លេខ 1-888-206-4697 (TTY: 1-800-442-7028) ។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697 (TTY: 1-800-442-7028) まで、お電話にてご連絡ください。