Provider Termination
Member Continuity of Care Request Form

Form completion tips

Complete and submit a Member Continuity of Care Request Form if your doctor or other health care provider is leaving your plan, and your member ID card says "Self Insured Coverage". It is important that your care is not disrupted while you look for a new doctor who is in your plan's network. You may be eligible to keep receiving care for a limited time.

Please do not complete and submit the form if you are not currently receiving care or if you do not have services scheduled. If your member ID card says "Fully Insured Coverage" you don't need to complete this form to be eligible.

Under New York law, if your plan is insured and you're in an ongoing course of treatment when your provider leaves the network, you may continue to be treated by the provider for up to 90 days. If you're pregnant, you can continue care through delivery and postpartum care. Your benefit plan terms will apply.

You also have rights to continue care under federal law. This includes care if you are:

- **In treatment for a serious and complex condition. This can be a sudden (acute) illness that requires specialized treatment in order to avoid death or permanent harm. It can also be an ongoing (chronic) illness that is life threatening or potentially disabling and requires specialized care over a long period of time.**
- **In a hospital or other inpatient facility.**
- **Scheduled for nonelective surgery by your current doctor, including your post–operative care for the surgery.**
- **Pregnant.**
- **Terminally ill.**

If you have questions or need help, please call us at the Member Services number on your ID card.

Please mail or fax this completed form to:

Mailing address	Fax number
Anthem Blue Cross and Blue Shield **Attention: Manager** **15 Plaza Drive** **Latham, NY 12110**	**888–892–0990**

1043204NYMENABS 12/23

Provider Termination
Member Continuity of Care Request Form

Instructions — Complete this form only if you are receiving care or scheduled to receive care from a provider who is leaving your plan's network, and your member ID card says "Self Insured Coverage". Please complete a separate form for each family member who may need continuity of care. If your member ID card says "Fully Insured Coverage" you don't need to complete this form to be eligible.

Subscriber information

Last name	First name	M.I.	Anthem member ID

Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)

Preferred phone no.	Secondary phone no.
( ) ☐Home ☐Cell ☐Work	( ) ☐Home ☐Cell ☐Work

Name of provider leaving your plan	Provider address	Provider phone no.

Describe your condition being treated by the provider leaving your plan. Include the date your care for this condition began.

Medical information

1. Do you have any upcoming appointments with the doctor leaving your plan? ☐Yes ☐No If Yes, please provide the details below.

Doctor/facility name (last, first)/ **Doctor/facility phone no.**	**Doctor/facility address**	Date of next office visit/ **Reason**	**Area of practice (specialty)**
Name: Phone:		Date: Reason:	
Name: Phone:		Date: Reason:	
Name: Phone:		Date: Reason:	
Name: Phone:		Date: Reason:	**Obstetrician for pregnancy** Due date:
Name: Phone:		Date: Reason:	**Behavioral health**

1043204NYMENABS 12/23

Medical information — Continued

2. Are you currently receiving any of the following services from the provider who is leaving your plan?

Oxygen	☐Yes ☐No	**Company:** _____
IV medication	☐Yes ☐No	**Company:** _____
Home therapy	☐Yes ☐No	**Company:** _____
Inpatient rehab treatment	☐Yes ☐No	**Company:** _____
Medical equipment	☐Yes ☐No	**Company:** _____
Dialysis	☐Yes ☐No	**Company:** _____
Laboratory	☐Yes ☐No	**Company:** _____
Radiation therapy	☐Yes ☐No	**Company:** _____

Other — please be specific: _____ ☐Yes ☐No **Company:** _____

3. Do you have any hospitalizations, surgeries or procedures scheduled with the provider who is leaving your plan? ☐Yes ☐No

Date: ____ **Type of surgery/procedure:** _____

Name/phone no. of physician performing surgery/procedure: _____

Hospital/facility: _____

4. Other needs/comments: _____

If you answered yes to any of the questions above, you will be contacted to coordinate your continuity of care, if appropriate.

Signature required

I authorize Anthem Blue Cross and Blue Shield to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐**Home** ☐**Cell** ☐**Work** ☐Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the Anthem Blue Cross and Blue Shield reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand that the Anthem Blue Cross and Blue Shield reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested Continuity of Care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over **X**	Printed name	Date (MMDDYYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MMDDYYYY)