Community Care Health Continuity of Care Request Form

See instruction for completing this form on the reverse side.

*****ATTENTION: You may not need to complete this form*****

> **Complete this form only if you are utilizing a non-participating health care professional. Please check your Community Care Health (CCH) provider directory or check the CCH website (www.communitycarehealth.org) to confirm that your doctor is in the CCH network.**

> See reverse for instruction to complete this Continuity of Care Request Form.

> Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

Employer	Policy #	Employee Date of Enrollment in CCH Benefit Plan (mm/dd/yyyy)
Employee Name	Employee Social Security #	Work Phone
Home Address Street City	State Zip	Home Phone

Patient's Name	Patient's Social Security #	Patient's Birthdate (mm/dd/yyyy)	Relationship to Employee ☐Spouse ☐Dependent ☐Self

1. Is the patient pregnant? ☐ Yes ☐ No
2. If yes, when is the due date? ____________________ (mm/dd/yyyy)
3. Is the patient currently receiving treatment for an acute condition or trauma? ☐ Yes ☐ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with CCH? ☐ Yes ☐ No
5. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or candidate for Organ Transplant? ☐ Yes ☐ No
6. Is the patient receiving treatment as a result of a recent major surgery? ☐ Yes ☐ No
7. Is the patient receiving mental health/substance abuse care? ☐ Yes ☐ No
8. Is the patient receiving care for a terminal illness? ☐ Yes ☐ No
9. If you did not answer "Yes" to any of the above questions, please described the condition for which the patient requests Continuity of Care.

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10. Please complete the provider information below.

Group Practice Name		
Doctor's Name		Telephone # of Provider
Doctor's Specialty		
Doctor's Address		
Hospital Where Patient's Doctor Practices		Telephone # of Hospital
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

11. Is this patient expected to be in the hospital when or after coverage with CCH begins? ☐ Yes ☐ No
12. Please list any other continuing care needs that may qualify for Continuity of Care benefits. If these are not related to the condition for which you are applying for Continuity of Care benefits, you must complete a separate Continuity of Care Form.

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I hereby authorize the above physician to provide CCH or any affiliated CCH company with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under CCH. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

INSTRUCTIONS FOR COMPLETING CONTINUITY OF CARE REQUEST FORM

A separate Continuity of Care Request Form must be completed for each condition for which you and/or your dependents are seeking Continuity of Care benefits. Please make certain that all questions are completely answered. When the form is completed, it must be signed by the patient for whom the Continuity of Care benefits have been requested. If patient is a minor, a guardian's signature is necessary.

The first few sections of the form apply to the Employee. When the form asks for the patient's name, only the name of the person who is actually undergoing care and is requesting Continuity of Care, should be reflected. The form should then be either emailed to: **CCHUtilizationManagement@communitycarehealth.org**
or sent by mail to:
Attention: Continuity of Care Department
P.O. Box 45020
Fresno, CA 93718
Fax: 1 (833) 853-8549

In #8, include information about your current or proposed treatment plan and the length of time your treatment is expected to continue. If surgery has been planned, state the type and the proposed date of your surgery.

In #11, briefly state the health condition, when it began and what provider is currently involved? How often do you see this provider?

To help ensure a timely review of your Continuity case, please return the form as soon as possible. You must apply for Continuity of Care benefits within 30 days of the provider's termination date. The completed forms should be marked "Confidential" and forwarded to the Healthcare Facilitation Center address above. CCH will notify you in writing of the approval or denial of your request.