# Community Care Health Continuity of Care Request Form

See instructions for completing this form on the reverse side.
Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

| Employer | Group # | Employee Date of Enrollment in CCH Benefit Plan (mm/dd/yyyy) |
|---|---|---|
| Employee Name | Employee's CCH Member ID # | Work Phone |
| Home Address Street City State Zip | | Home/Cell Phone |

| Patient's Name | Patient's CCH Member ID # | Patient's Birthdate (mm/dd/yyyy) | Relationship to Employee ☐Spouse ☐Dependent ☐Self |
|---|---|---|---|
| | | | |

1. Is the patient asking to keep his/her Primary Care Physician (PCP) who is leaving the network? ☐ Yes ☐ No
   If "yes", # of times the patient has seen the PCP in the past year _____
2. Is the patient pregnant? ☐ Yes ☐ No
   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? ☐ Yes ☐ No
5. Is the patient involved in a course of chemotherapy, radiation therapy, other cancer treatment or a 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 care for a mental health/substance use disorder? ☐ Yes ☐ No
8. Is the patient receiving care for a terminal illness? ☐ Yes ☐ No

If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Continuity of Care: _____

| Please complete the provider information below. Some of the requested information may not apply to you. | |
|---|---|
| Provider's Name | Phone # |
| Provider's Specialty (if known) | |
| Provider's Address | |
| Date of Surgery (mm/dd/yyyy) | Type of Surgery |

9. If the patient is a new enrollee, is he/she expected to be in the hospital when or after coverage with CCH begins? ☐ Yes ☐ No
10. Please list below any other continuing care needs that may qualify for Continuity of Care. If these are not related to the condition for which you are applying for Continuity of Care, you must complete a separate Continuity of Care Form.
    _____

| I hereby authorize the above provider to provide CCH or CCH's designee with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care. 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 THE CONTINUITY OF CARE REQUEST FORM

A separate Continuity of Care Request Form must be completed for each condition for which you and/or your dependent is seeking Continuity of Care. Please make sure that all questions are completely answered. If you need help in completing the form, call us at 1-833-549-2945. 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 parent's or 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.**

To help ensure a timely review of your Continuity of Care request, please return the form as soon as possible. If you are requesting Continuity of Care with a terminated provider, you must apply within 30 days of the provider's termination date. Exceptions to the 30 calendar day time frame will be considered for good cause. CCH will notify you in writing of the approval or denial of your request.

The completed form should be emailed to: COC@communitycarehealth.org or sent by mail or fax to:

Community Care Health
Attn: Continuity of Care Department
P.O. Box 45026
Fresno, CA 93718
Fax: 1-559-599-0022