



Horizon Blue Cross Blue Shield of New Jersey

CONTINUITY OF CARE COVERAGE AGREEMENT

As outlined in our *Credentialing and Recredentialing Policy for Participating Physicians and Healthcare Professionals*, Horizon Blue Cross Blue Shield of New Jersey allows primary care physicians (i.e., family practitioners, pediatricians and internal medicine) and specialists who elect to limit their practices to providing services in their offices to satisfy the policy's requirement to obtain participating hospital admitting privileges by establishing an arrangement with other, participating acute care physician(s) or physicians' group(s) to care for his/her patients who require acute care at a network hospital.

By completing, signing and returning this form, you and the physician(s)/physicians' group(s) identified attest that such an arrangement has been established. This form will be included in your credentialing file and reviewed by our credentials committee.

Completed and signed forms may be mailed to: Horizon BCBSNJ
Credentialing & Recredentialing Department
3 Penn Plaza East, PP-14C
Newark, NJ 07105-2200

I, the applicant, in accordance with *Horizon BCBSNJ's Credentialing and Recredentialing Policy for Participating Physicians and Healthcare Professionals*, have arranged for patients requiring hospitalization to be admitted under the care of the physician(s)/physicians' group(s) noted below at the Horizon BCBSNJ network hospital or BlueCard® hospital noted below.

To ensure continuity of care, I, the applicant, working with the admitting physician(s)/physicians' group(s) noted below will:

- Provide all relevant current and past medical history and pertinent records.
- Obtain notification of discharge and a copy of the hospital discharge summary.
- Make arrangements for a follow-up appointment within an appropriate time frame.

(Applicant's name please print)

(Applicant's NPI number)

Applicant Signature: _____ Date: ____/____/____
MM DD YYYY

I/we, the admitting physician(s)/physicians' group(s) agree to the above arrangement.

To ensure continuity of care, I/we, the admitting physician(s)/physicians' group(s), will provide to the applicant noted above:

- All medical notes and pertinent hospital records.
- Notification of discharge and a copy of the hospital discharge summary.

Name: _____ NPI: _____

Group Name: _____ NPI: _____

Network/BlueCard® Hospital Name: _____

Signature: _____ Date: ____/____/____
MM DD YYYY

Name: _____ NPI: _____

Group Name: _____ NPI: _____

Network/BlueCard® Hospital Name: _____

Signature: _____ Date: ____/____/____
MM DD YYYY