North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

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, please call 1-800-367-6143 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 _____

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 _____

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