

## Request for Continuity of Care Service for New Access+ HMO Enrollees

Please complete all sections and return this signed form with a copy of your Blue Shield enrollment form (when enrollment is not submitted electronically) to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540, (800) 424-6521

### Section 1 – Employer and employee identification

Employee name		Date of birth (mo/day/yr)	Member ID number	
Effective date on the plan		Day time phone number ( )	Home phone number ( )	
Group number				
Mailing address	City	State	ZIP	
Employer name		Employer address		

### Section 2 – Patient identification

Patient's name	Date of birth (mo/day/yr)	Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse/domestic partner	
Daytime phone number ( )			
Name of patient's Blue Shield HMO Personal Physician		Physician's phone number ( )	
Name of patient's IPA/medical group			

### Section 3 – Prior health plan coverage information

Name of health plan prior to Blue Shield	
Prior health plan identification number	Subscriber name
Was your prior healthcare coverage HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of the group
Was your prior healthcare coverage PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient currently covered by a second health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, health plan identification number
Name of health plan	
Address of health plan	Phone number ( )

(see reverse)

## Section 4 – Medical information

Name and address of current attending physician, specialist, or midwife

Attending physician's phone number ( )

Fax number ( )

Condition or diagnosis being treated

Is patient hospitalized now?  Yes  No

If Yes, name and address of hospital

Is patient on medical leave of absence (LOA)?  Yes  No

On medical disability?  Yes  No

Are you requesting continued care for a child who is newborn to 36 months of age?  Yes  No

Is the patient scheduled for medical treatment on either an inpatient or outpatient basis?  Yes  No

If Yes, provide the scheduled date, name of physician/hospital, and describe planned treatment

Is the patient currently receiving home health or hospice care?  
 Yes  No

If Yes, name and address of the home healthcare agency or hospice provider

Does the patient have a terminal condition?  Yes  No

Is the patient pregnant?  Yes  No

If Yes, what is the expected date of delivery?

Name and address of hospital

Is the patient currently receiving home medical equipment?  
 Yes  No

If Yes, name and address of the home medical equipment provider

## Section 5 – Additional information to be considered

## Section 6 – Member certification, authorization, and signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize any physician, health care facility, other provider of health care, insurance carrier, hospital, or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness, injury or condition, examination, or treatment, including records of billings, benefits or payments, which this patient received at any time. This information is collected to evaluate and process this request.

Subscriber signature \_\_\_\_\_ Date \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**To assist us in processing your request, please attach a copy of your Blue Shield enrollment form.**

### Blue Shield office use Only

Sales representative name	Phone number
Service representative name	Extension
Employer group number	Health plan effective date
IPA/medical group number	