CareFirst Medicare Advantage

# Information on Continuity of Care Instructions

## Welcome to CareFirst

One of your concerns as you seek enrollment in a CareFirst BlueCross BlueShield Medicare Advantage (CareFirst Medicare Advantage) plan may be continuity of treatment. CareFirst Medicare Advantage members who receive care from an out-of-network physician for an unstable or serious medical condition may be eligible for the Continuity of Care process.

## What is Continuity of Care?

If your request is approved, the Continuity of Care process allows you to continue to receive care from an out-of-network physician for up to 90 days following the date of enrollment. Benefits will be paid at the in-network level (i.e., minimal copayments and no calendar year deductible.)

## Who should use this form?

If you have an unstable or serious medical condition that requires a limited course of treatment or follow-up care, and are currently being treated by a specialist who is not a CareFirst Medicare Advantage participating provider, you should complete this form. Information is required from both you and your physician.

Please be sure to submit a separate form for each non-participating physician currently treating you for an unstable or serious medical condition. Your newly selected participating CareFirst Medicare Advantage physician must coordinate any other unrelated treatment for you.

**Note:** If the physician treating your condition participates in the CareFirst Medicare Advantage network, it is not necessary to complete this form. Instead, contact your new primary care physician to discuss the current treatment.

Examples of medical conditions that may qualify for the Continuity of Care process include:

- Pregnancy (beyond 24 weeks gestation)
- Bone fractures
- Recent heart attack
- Other acute trauma or surgery
- Joint replacement
- Newly diagnosed cancer
- Other serious medical conditions where the member is in active treatment

Examples of chronic medical condition that typically are not eligible for the Continuity of Care process include:

- Allergies
- Arthritis
- Asthma
- COPD/emphysema
- Diabetes
- Hypertension

Please complete the Patient Information section on the  Request for Continuity of Care form. Also, have the physician complete the Physician Information section. Return the form to the following address **before the effective date of your coverage**. No forms will be accepted after that date.

Qualified medical professionals in the CareFirst Medicare Advantage Care Management Department will review the request and notify your provider of a determination by phone within two business days following the receipt of all required information. If the services are not approved, you and your provider will also be notified in writing.

# Request for Continuity of Care Form

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## INSTRUCTIONS

Mail the completed form and any attachments to: CareFirst Medicare Advantage, Utilization Management Department, 10455 Mill Run Circle, Room 11113-A, Owings Mills, MD 21117

Or fax the completed form and any attachments to: 443-753-2341, Attention: Utilization Management

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**.

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Member's Name | | Date of Birth | |
| Street Address | | Member ID # | |
| City | | Group Name | Effective Date of Coverage |
| State | Zip Code | Group # | Check below:<br>○ Medicare Advantage |
| Home Telephone | | | |

## PATIENT INFORMATION

| | |
|---|---|
| Patient's Name | Patient's Date of Birth |

## PHYSICIAN INFORMATION

| | | |
|---|---|---|
| Name of Physician Currently Treating Condition | Diagnosis Code(s) (ICD-10) | Date Treatment Started |
| Specialty | Procedure Code(s) (CPT/HCPCS) | Date of Next Treatment/Visit |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| Street Address | | For Pregnancy, Please Indicate the Patient's Anticipated Due Date |
| City | | Please attach the following:<br>○ List of services that may already be scheduled in the next few weeks (CPT code and date, provider)<br>○ A brief statement of the patient's current condition and treatment plan<br>○ Copies of any pertinent documentation (e.g., lab results, X-rays) |
| State | Zip Code | |
| Telephone | | |
| Physician's Signature | | Date |

This information will be used for determining the appropriate level of benefit reimbursement for services provided on or after the effective date of my CareFirst Medicare Advantage coverage, if I continue treatment with the above named provider for the above diagnosis/medical condition.

I understand that Continuity of Care is granted at the discretion of CareFirst and is subject to contractual limitations and exclusions set forth in the group contract. I understand and agree that Continuity of Care does not extend the contractual benefits in any way, except to provide in-network level benefits for a non-network provider for a temporary time period.

*If the patient is younger than 18, the subscriber must sign this form.

| | |
|---|---|
| Patient's Signature | Date: |
| Subscriber's Signature* | Date |