Request for continuity of care

Instructions

Fax the completed form and any attachments to: 501-301-1993, Attention: Clinical Review

Or email the completed form and any attachments to: clinicalresearchteam@arkbluecross.com.

Please complete a separate form for each policyholder or dependent that is requesting an exception.

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.

Insurance information

Member's name	**Date of birth** (mm/dd/yyyy)	**Effective date of coverage**

Street or PO box	**City**	**State**	**ZIP**

Phone	**Member ID number**	**Email**

Patient information

Patient's name	**Date of birth**	**Email** (optional)

Physician information

To expedite request, please have your physician complete the below information

Name of physician currently treating condition(s)	**Diagnosis code(s) (ICD-10)**	**Date treatment started**

Specialty	**Physician TIN/NPI**	**Procedure code(s) (CPT/HCPCS)**	**Date of next treatment/visit**

For pregnancy, please indicate if high risk	**Due date**	**Weeks gestation**

Street or PO box	**City**	**State**	**ZIP**

Please attach a list of the following:

☐ List of services that may already be scheduled in the next few weeks (CPT code and date, provider)

☐ A brief statement of the patient's current condition(s) and treatment plan(s)

Signatures

Physician's signature	Date signed

The information provided on this form will be used for determining the appropriate level of reimbursement for services provided on or after the effective date of my Arkansas Blue Cross and Blue Shield coverage, if I continue treatment with the named provider for the diagnosis or procedure codes referenced in this form.

I understand that Continuity of Care is granted at the discretion of Arkansas Blue Cross and subject to any contractual limitations and exclusions in the benefit plan. This continuity of care exception applies only to the physician listed above regarding medical conditions, and/or treatment plans listed, for the lesser of 90 days or the end of the treatment.

I hereby authorize the above health care provider to give Arkansas Blue Cross and Blue Shield or its affiliates or contracted parties any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care. I understand that I am entitled to a copy of this authorization request form.

By signing below, I agree that a copy of the dispensation of this application will be shared with my provider referenced within this application by **mail or email.**

Please send the decision about this application to:

☐ My email

☐ My address

☐ Both my email and my address

Patient's signature (if older than 18)	**Date signed**
Policyholder/Guardian's signature	**Date signed**

Any person who knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.