

Form completion tips

Complete and submit a *Continuity of Care Request Form* if your doctor or other health care provider is leaving your plan. It is important that your care is not disrupted while you look for a new doctor who is in your plan's network. You may be eligible to keep receiving care for certain conditions or scheduled services for a limited time.

Please do not complete and submit the form if you are not currently receiving ongoing care or if you do not have upcoming services scheduled.

Please complete and submit a *Continuity of Care Request Form* if any of the circumstances listed below apply:

- You are in treatment for a serious and complex condition. (This can be a sudden illness that requires specialized treatment in order to avoid death or permanent harm. It can also be an ongoing illness that is life threatening or potentially disabling and requires specialized care over a long period of time.)
- You are in a hospital or other inpatient facility.
- You are scheduled for non-elective surgery by your current doctor, including your post-operative care for the surgery.
- You are pregnant.
- You are terminally ill.

If you have questions or need help, please call us at the Member Services number on your ID card.

Please mail or fax this completed form to:

State	Mailing address	Fax number
Colorado	Anthem Blue Cross and Blue Shield Attn: Anthem Blue Cross and Blue Shield, HS0535 700 Broadway Denver, CO 80273	800-763-3142
Connecticut	Anthem Blue Cross and Blue Shield Attn: Medical Management Department 108 Leigus Road Wallingford, CT 06492	877-539-3851
Georgia	6087 Technology Pkwy Mail Drop GA081W-0012 Midland, GA 31820	877-254-4971
Indiana	Indiana Anthem UM Services, Inc. Attn: COC - UM Mailpoint: IN0205-A599 220 Virginia Avenue Indianapolis, IN 46204	866-959-1395
Kentucky	Kentucky Anthem UM Services, Inc. Attn: COC - UM Mailpoint: IN0205-A599 220 Virginia Avenue Indianapolis, IN 46204	800-730-6061
Maine	Anthem Blue Cross and Blue Shield Attn: Medical Management Department 2 Gannett Drive South Portland, ME 04106	877-539-3855
Missouri	Missouri Anthem UM Services, Inc. Attn: COC - UM Mailpoint: IN0205-A599 220 Virginia Avenue Indianapolis, IN 46204	866-959-1393

State	Mailing address	Fax number
Nevada	Anthem Blue Cross and Blue Shield Attn: Anthem Blue Cross and Blue Shield, HS0535 700 Broadway Denver, CO 80273	800-763-3142
New Hampshire	Anthem Blue Cross and Blue Shield Attn: Medical Management Department 108 Leigus Road Wallingford, CT 06492	877-539-3860
Ohio	Ohio Anthem UM Services, Inc. Attn: COC – UM Mailpoint: IN0205-A599 220 Virginia Avenue Indianapolis, IN 46204	800-266-3504
Virginia	Anthem Blue Cross and Blue Shield Medical Management Mail Drop VA44A P.O. Box 27401 Richmond, VA 23279	866-552-9777
Wisconsin	Wisconsin Anthem UM Services, Inc. Attn: COC – UM Mailpoint: IN0205-A599 220 Virginia Avenue Indianapolis, IN 46204	866-959-2154
Transplant	Transplant for IN, KY, MO, OH, and WI (CR Local only) Transplant Department Anthem Blue Cross and Blue Shield 13550 Triton Park Blvd. Mail Stop: KY0304-A670 Louisville, KY 40223 Transplant for National Accounts email: Transplant_IHM@anthem.com	CR Local only: 866-255-2471 National: 888-438-7051
National Accounts Only applicable to NY, GA, and CR National	Buy Up COC form – This is applicable only for IHM, MHA, CCMU, and THTY accounts. Buy Up address: Anthem Blue Cross and Blue Shield National Accounts Attn: National Accounts Medical Management 15 Plaza Drive Mail Drop: NY59-15-3L-9999 Latham, NY 12210 CCM form is to use for all CCM National accounts. Anthem Blue Cross and Blue Shield Attn: National Continuation of Care Coordinator 220 Virginia Avenue Mailpoint: IN0205-A546 Indianapolis, IN 46207-7101	Buy Up: 888-438-7061 CCM: 800-773-7797
GA State Health Benefit Plan (SHBP)	740 W Peachtree St. NW Atlanta, GA 30308 Phone no: 855-641-4862	855-410-4455

Provider Termination Continuity of Care Request Form



Instructions — Complete this form only if you are receiving ongoing care, or are scheduled to receive care, and your provider is leaving the Anthem network. Please complete a separate form for each family member who may need continuity of care.

Subscriber information

Last name	First name	M.I.	Anthem member ID
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Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)
Preferred phone no. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Secondary phone no. ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Diagnosis requiring continuity of care (include pertinent history and physical findings)			

Medical information

1. Do you have an upcoming appointment to see a specialist? ☐ Yes ☐ No If yes, please provide the applicable information below.

Type	Physician name (last, first)/ Physician phone no.	Physician address	Date of next office visit/ Reason
Heart specialist	Name: Phone:		Date: Reason:
Lung specialist	Name: Phone:		Date: Reason:
Blood or cancer specialist	Name: Phone:		Date: Reason:
Neurologist	Name: Phone:		Date: Reason:
Surgeon	Name: Phone:		Date: Reason:
Obstetrician for pregnancy Due date:	Name: Phone:		Date: Reason:
Other — please be specific: _____	Name: Phone:		Date: Reason:

Medical information — Continued

2. Are you currently receiving any of the following services?

Oxygen ☐ Yes ☐ No Company: _____

IV medication ☐ Yes ☐ No Company: _____

Home therapy ☐ Yes ☐ No Company: _____

Inpatient rehab treatment ☐ Yes ☐ No Company: _____

Medical equipment ☐ Yes ☐ No Company: _____

Dialysis ☐ Yes ☐ No Company: _____

Laboratory ☐ Yes ☐ No Company: _____

Radiation therapy ☐ Yes ☐ No Company: _____

Other — please be specific: _____ ☐ Yes ☐ No Company: _____

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No

Date: Type of surgery/procedure: _____

Name/phone no. of physician performing surgery/procedure: _____

Hospital/facility: _____

4. Other needs/comments: _____

If you answered yes to any of the questions above, you will be contacted to coordinate your continuity of care, if appropriate.

Signature required

I authorize Anthem Blue Cross and Blue Shield to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the Anthem Blue Cross and Blue Shield reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand that the Anthem Blue Cross and Blue Shield reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over X	Printed name	Date (MMDDYYYY)
Signature of parent or guardian if patient is under age 18 X	Printed name	Date (MMDDYYYY)