Community Care Health
Continuity of Care Request Form

See instructions for completing this form on page 2.
Photocopies are acceptable. Attach additional information if necessary.

COMMUNITY CARE HEALTH

Employer	Group #	Employee Date of Enrollment in CCH Benefit Plan (mm/dd/yyyy)	
Employee Name	Employee's CCH Member ID #	Work Phone #	
Home Address, City, State, Zip		Home/Cell Phone #	
*Member Name	Member ID #	Member DOB (mm/dd/yyyy)	Relationship to Employee ☐ Spouse ☐ Dependent

The member who is undergoing care from the provider identified below.

1. **Does the member have an acute condition?** This is a medical condition with a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and lasts for a limited time. ☐ Yes ☐ No
If yes, please describe: _____

2. **Does the member have a serious chronic condition?** This is a medical condition that is serious in nature and that continues without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. ☐ Yes ☐ No
If yes, please describe: _____

3. **Is the member pregnant?** This includes the three trimesters of pregnancy and the immediate postpartum period. ☐ Yes ☐ No
Continuing care may also apply to a maternal mental health condition that extends beyond the postpartum period.
Does the member have a documented maternal mental health condition? ☐ Yes ☐ No
If yes to one or both of the above, please describe: _____

4. **Does the member have a terminal illness?** This is an incurable or irreversible condition that has a high probability of causing death within one year or less. ☐ Yes ☐ No If yes, please describe: _____

5. **Is the member a child age 36 months or less?** ☐ Yes ☐ No
If yes, please describe: _____

6. **Does the member have a scheduled surgery or other procedure** that CCH authorized to occur within 180 days of the contract's termination date (in the case of a terminated provider), or to take place within 180 days of the effective date of coverage (in the case of a newly covered enrollee)? ☐ Yes ☐ No
If yes, please provide the following: Date Scheduled: _____ Surgery/procedure: _____
Name of facility where surgery/procedure to be performed: _____

New enrollees only: Did you have the option to enroll in a health plan with an out-of-network option? ☐ Yes ☐ No
Did you have the option to continue with your previous health plan or provider, but you voluntarily chose to change health plans? ☐ Yes ☐ No
IMPORTANT: If the answer is "yes" to either of the above, you are not eligible for continuity of care.

Please complete the provider information below.	
Provider's Name	Phone #
Provider's Specialty (if known)	
Provider's Address	

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize the above provider to provide CCH or CCH's designee with all information and medical records necessary to make an informed decision concerning my request for continuity of care. I understand I am entitled to a copy of this authorization form.

X _____ _____

Signature of Patient, Parent or Guardian Date

Instructions

CCH is required to allow a member to continue to see a provider who is leaving the CCH network, or a newly-covered member to continue to see a provider who is not in the CCH network, for a limited period of time if certain conditions are met.

If you or a dependent would like to continue receiving services from a terminated or out-of-network provider, please complete this form. You can find more information about continuity of care on our website, including our Continuity of Care Policy, at: www.communitycarehealth.org/continuity-of-care-benefits

All questions on the form must be answered in full in order for us to determine eligibility for continuing care. The form must be signed by the member who is the patient. If the patient is a minor, a parent's or guardian's signature is necessary. If you need help in completing the form, call us at 1 (559) 724-4995.

To help ensure a timely review of your request, please return the completed and signed form as soon as possible. If you are requesting continuity of care with a terminated provider, you must apply within 30 days of the provider's termination date. If you are a new enrollee requesting continuity of care with an out-of-network provider, you must apply within 30 days of your enrollment effective date. Exceptions to the 30-day time frame will be considered for good cause. We will notify you in writing whether or not we have approved your request.

The completed and signed form should be emailed to us at: UM@communitycarehealth.org or sent by mail or fax to:

Community Care Health
Attn: Continuity of Care Department
P.O. Box 45016
Fresno, CA 93718
Fax: 1 (559) 724-4750