Continuity of Care Form

Continuity of care will be issued under special circumstances to allow members to continue treatment with a non-plan provider(s) for a period of time following the date of enrollment. Please complete this form if you are currently being treated by a non-plan provider. One form must be submitted for each provider.

• Unstable or serious medical problems that require a limited course of treatment or follow-up care, such as those listed below may be eligible for continuity of care:
  • Newly diagnosed cancer
  • Recent heart attack
  • Other ongoing acute care

• Members with special needs that require treatments to maintain a level of function will be reviewed on a case by case basis.

• Examples of chronic medical conditions which are NOT typically eligible for continuity of care include:
  • Arthritis
  • Diabetes
  • Hypertension (high blood pressure)
  • Asthma and allergies

• If the treating physician is in the Memorial Hermann Advantage network, do NOT complete this form. Please refer to the physician listing at URL: healthplan.memorialhermann.org/medicare or call customer service at 855.645.8448 available 8 a.m. to 8 p.m. Monday – Friday, Feb 15 – Sept 30; 8 a.m. to 8 p.m., 7 days a week, Oct 1 – Feb 14 (TTY 711).

• If you have any questions about continuity care or need help completing this form, please call the Memorial Hermann Advantage (MHA) Medical Management Department at: 855.645.8448 (TTY 711).

• Please ask your treating physician to fax any clinical information related to this continuity of care request to the MHA Medical Management Department at 713.338.6982.

CONTINUITY OF CARE INFORMATION

Member Information

Member’s Name: _____________________________ DOB: _________

Effective Date of Coverage: ____________

Member ID: _______________________

Preferred Contact Telephone Number: ____________________________
Condition being treated: 
________________________________________________________________________

How long has the doctor been treating the member for the current condition?  
___________ Years __________ Months

How long is the treatment expected to continue?  
___________ Years __________ Months

What is the nature of the treatment?  
________________________________________________________________________

Was the member hospitalized recently for this condition?  Yes  No  
Admission Date: ________________________

Did the member have surgery?  Yes  No  
What Type? ____________________________  
When? _______________

Non-Contracted Provider Information  
Name: _______________________________________________

Tax ID or NPI#:___________________________

Street Address: 
____________________________________________________________________________

City: __________________________ State: _______________________

Zip Code: ________________

Telephone Number: ____________________________

Specialty: ___________________________________

Hospital or facility where surgery or treatment is scheduled or currently being provided:  
________________________________________________________________________

Telephone number of hospital or facility: ____________________________
AUTHORIZATION TO RELEASE INFORMATION PERSONAL HEALTH INFORMATION

I authorize
___________________________________________________________

(Provider Name)

to release to MHA Medical Management Department all information relating to past, present,
and future health care examinations, conditions, and treatments for:
______________________________________________________________

______________________________________________________________

(Brief Description of Medical Condition)

This information will be used to determine if services for the above provider for the stated
condition may be covered on or after the effective date by MHA Medical Management
Department. I also understand that MHA does not extend the contractual benefits in any way
except to provide coverage for the non-plan provider for a temporary time period.

Member’s Signature: ____________________________
Date: ________________

Member Representative Signature: ____________________________
Date: ________________

FOR OFFICE USE ONLY

Approved  |  Denied  |  Explanations/limitations

Medical Director/Designee: ____________________________  Date: ________________

TO MEMBER: Please complete this form and return it to the following address:

Memorial Hermann Advantage
Medical Management Department
929 Gessner Rd, Suite 1500
Houston, TX 77024
Fax to: 713.338.6982