

## 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 or one of your dependents is currently being treated by a non-plan provider. One form must be submitted for each provider. The following is a list of services that may or may NOT be considered for continuity of care.

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:

- Pregnancy or high risk
- Heart attack
- Newly diagnosed cancer
- Other ongoing acute care

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

Examples of chronic medical conditions which are typically NOT eligible for continuity of care include:

- Arthritis
- Hypertension
- Diabetes
- Asthma and allergies

If the treating physician is in the Memorial Hermann Health Plan network, do NOT complete this form. Please refer to the physician listing on <https://healthplan.memorialhermann.org/> or call customer service at (855) 645-8448.

If you have any questions about continuity care or need help completing this form, please call the Memorial Hermann Health Insurance Company Medical Management Department at (855) 645-8448.

Please ask your treating physician to fax any clinical information related to this continuity of care request to the Memorial Hermann Health Plan Medical Management Department at (713) 338-6494.

| EMPLOYEE / SUBSCRIBER INFORMATION |        |           |
|-----------------------------------|--------|-----------|
| Employee's Name:                  |        |           |
| Street Address:                   |        |           |
| City:                             | State: | Zip Code: |
| Preferred Contact Phone Number:   |        |           |
| Effective Date of Coverage:       |        |           |
| Employer Name:                    |        |           |

## CONTINUITY OF CARE INFORMATION

### MEMBER INFORMATION

Member's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relation to Employee: \_\_\_\_\_

Condition being treated: \_\_\_\_\_

How long has the doctor been treating the Member for this condition? \_\_\_\_\_ Years \_\_\_\_\_ Months

How long is treatment expected to continue? \_\_\_\_\_ Years \_\_\_\_\_ Months

What is the nature of the treatment? \_\_\_\_\_

\_\_\_\_\_

Was the Member recently hospitalized for this condition? ☐ Yes ☐ No

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Did the Member have surgery? ☐ Yes ☐ No

Type of Surgery? \_\_\_\_\_ Date: \_\_\_\_\_

If pregnancy-related, list date of initial visit: \_\_\_\_\_ LMP: \_\_\_\_\_

Estimated Delivery Date: \_\_\_\_\_

### NON-CONTRACTED PROVIDER INFORMATION

Provider's Name: \_\_\_\_\_ Tax ID or NPN#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Provider's Specialty: \_\_\_\_\_

Name of Hospital or facility where surgery, treatment, or delivery is being provided or scheduled to be provided:

\_\_\_\_\_

Telephone number of hospital or facility: \_\_\_\_\_

## AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I authorize \_\_\_\_\_ (*Provider's Name*) to release to Memorial Hermann Health Plan 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 Memorial Hermann Health Plan Medical Management Department. I understand that continuity of care is subject to contractual limitations and exclusions set forth in the subscriber contract. I also understand that Memorial Hermann Health Plan does not extend the contractual benefits in any way except to provide coverage for the non-par Provider for a temporary time period.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Employee / Legal Guardian:

\_\_\_\_\_  
Date

\*If patient is younger than 18 years of age, the Employee or Legal Guardian must sign this form to authorize the release of medical information.

Please complete this form and return to the following address:

**Memorial Hermann Health Plan  
Medical Management Department  
P. O. Box 19909  
Houston, TX 77224-1909  
Or Fax to: (713) 338-6494**

| FOR OFFICE USE ONLY                |        |                          |
|------------------------------------|--------|--------------------------|
| Approved                           | Denied | Explanations/Limitations |
| _____<br>Medical Director/Designee |        | _____<br>Date            |