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 (minimum 90 days) 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 (832) 476-1962

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: (832) 476-1962

FOR OFFICE USE ONLY		
Approved	Denied	Explanations/Limitations
_____ Medical Director/Designee		_____ Date