Continuity of Care Form
(For Colorado and Nevada use only)

Anthem

To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care. Fill out the form completely, and do not leave any blanks.* Please complete a separate form for each covered family member who needs to have care transitioned to another provider.

SUBSCRIBER INFORMATION

Last name	First name	M.I.	Subscriber no.

PATIENT INFORMATION

Last name	First name	M.I.	Patient ID no.

Daytime phone no.	Home phone no.
( )	( )

Current primary care physician/attending physician

New primary care physician/attending physician

MEDICAL INFORMATION

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

Type	Physician name (last, first)	Physician phone no.	Date of service (MM/DD/YYYY)
Heart specialist			___/___/___
Lung specialist			___/___/___
Blood or cancer specialist			___/___/___
Neurologist			___/___/___
Infectious disease specialist			___/___/___
Kidney specialist			___/___/___
Surgeon			___/___/___
Other: please be specific			___/___/___

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

Oxygen ☐ Yes ☐ No Company_____
IV medication ☐ Yes ☐ No Company_____
Home therapy ☐ Yes ☐ No Company_____
Rehab treatment ☐ Yes ☐ No Company_____
Medical equipment ☐ Yes ☐ No Company_____
Dialysis ☐ 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. Have you been admitted to the hospital or seen in the emergency room in the past six months?
☐ Yes ☐ No Reason_____
Hospital_____ Date(s) of service_____

5. Are you currently pregnant? ☐ Yes ☐ No If yes, due date_____
Name of OB physician_____

6. Other needs/comments_____

If you answered yes to any of the questions above, a nurse will contact you to coordinate your continuity of care, if appropriate. Please mail this completed form to Anthem Blue Cross and Blue Shield, HS0535, 700 Broadway, Denver, CO 80273 or fax the completed form to 303-764-7030.

FORM COMPLETION TIPS

Complete and submit a Continuity of Care Form if you are currently receiving ongoing care or if you have services scheduled. **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.**

You, your current physician or a member of your physician's staff may complete and submit the form. Please be sure to include the name of your new primary care physician (PCP) or primary medical group (PMG) on the form. If that information is omitted, we will call you and request that you select a PCP or PMG as soon as possible. Please mail or fax the completed form to the address/fax number provided at the bottom of the front page of this form.

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

I. **You currently need a referral to an in- or out-of-network specialist.**

II. **You are currently receiving or are scheduled to receive any of the following:**
- Prenatal/obstetrical care
- Elective surgery
- Ongoing treatment for an acute inpatient stay
- Discharge planning after an acute inpatient stay, even if your previous health insurance carrier is still following your care
- Dialysis
- Home health care
- Hospice care
- Home IV therapy
- Inpatient rehabilitation
- Durable medical equipment
- Supplies

III. **Your medical condition includes any of the following:**
- You are medically impaired and unable to move without the aid of a mechanical device.
- You have limited ability to move from place to place.
- You experience hardship in travel, which threatens your safety or welfare.