COUPE HEALTH

CONTINUITY OF CARE REQUEST FORM

Continuity of Care is available to members receiving certain medical care by a physician, hospital or other provider whose contractual relationship with Coupe Health is voluntarily terminating or has terminated. Continuity of Care allows a specified transition period to provide consistent quality medical care while a new provider is identified.

Benefit levels provided as part of Continuity of Care are for the specific illness or condition(s) listed and cannot be applied to any other illnesses or condition(s). You must complete a Continuity of Care Request form for each condition and return no later than 90 days after the date of notification letter.

Patient Information

Patient's First Name	Middle Initial	Last Name	Date of Birth:
Contract Holder's First Name (if applicable)	Middle Initial	Last Name	Relationship to Patient:
Contract Number *(include prefix)*		Group Number	Sex of Patient: ☐ Male ☐ Female
Work Telephone	Home or Cell Telephone	Email	
Address	City	State	Zip

Physician Information *(to be filled out by Physician)*

Physician Name	Physician's Specialty	Individual NPI *(National Provider Identifier)*		
Address	City	State	Zip	Physician's Telephone

1. Is the patient pregnant? ☐ Yes ☐ No
   - If yes, when is the due date? _____ *(mm/dd/yyyy)*

2. Medical condition for continuity of care consideration:

_____

_____

3. Diagnosis *(also give ICD-9 code)*:

4. Member's Condition and Current Treatment Plan – Please include the anticipated length of time the continuity of care services are requested and any narratives or copies of medical records that will facilitate the evaluation process for your patient:

_____

_____

_____

I support this member's request for continuity of care. As the physician, I understand that should Coupe Health approve this continuity of care service request, I and/or any terminated facility will be required to comply with all applicable continuity of care laws and regulations.

Physician Signature _____ Date *(mm/dd/yyyy)* _____

Hospital Information

Hospital Name *(where patient's doctor practices)*			Hospital Telephone
Address	City	State	Zip

I certify this information is complete and correct to the best of my knowledge.

Each case will be considered individually, and approval is only for treatment of the specific health condition. Benefits are subject to the contractual limitations and exclusions set forth in the member's contract/certificate. Any approval of continuity of care does not extend the contractual benefits in any way except to provide in-network level of benefits for a non-network provider for a temporary time period.

Printed Name of Patient, Parent or Guardian _____ Signature of Patient, Parent or Guardian _____ Date *(mm/dd/yyyy)* _____

Mail to: Birmingham Service Center • P.O. Box 2684 • Birmingham, AL 35283-2684 or **Fax:** 833-541-5743