

Request for Continuity of Care Service for Established Members

Complete all sections and return this form to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540, (800) 424-6521

Section 1 – Subscriber information

Subscriber name		Date of birth (mo/day/yr)	ID number	
Address	City	State	ZIP	
Home phone number ()		Daytime phone number ()		

Section 2 – Patient information

Patient's name		Date of birth (mo/day/yr)	Relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse/domestic partner	
Address (if different from above)	City	State	ZIP	
Name of Blue Shield Personal Physician		Physician's phone number ()		

Section 3 – Medical information

Physician(s) from whom the member is requesting continued care	
Address	Address
Phone number ()	Phone number ()

Condition or diagnosis being treated

Has member received any medical treatment from the provider who is leaving the Blue Shield network of providers in the last 30 days? Yes No

If Yes, please list the medical treatment received

Does the member have routinely scheduled visits with a physician for either monitoring or treatment of a medical condition including prescription medications? Yes No

If yes, please list the physician and treatment (including prescription medications) being received

Are you requesting continued care for a child who is newborn to 36 months of age? Yes No

(see reverse)

Section 3 – Medical information (continued)

Is the member pregnant? Yes No

If yes, what is the expected date of delivery? _____

Name of hospital _____

Name and address of attending physician/midwife _____

Is the member currently hospitalized? Yes No

If yes, name and address of hospital _____

Is the member currently receiving home health or hospice care? Yes No

If yes, provide the date scheduled, physician/hospital, and describe planned treatment _____

Does the member have a terminal condition? Yes No

Section 4 – Additional information to be considered

Section 5 – Member certification, authorization, and signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize any physician, healthcare facility, other provider of health care, insurance carrier, hospital, or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness, injury or condition, examination, or treatment, including records of billings, benefits or payments, which this patient received at any time. This information is collected to evaluate and process this request.

Name of member responding _____

Member signature _____ Date _____

Phone number where we may reach you _____