Continuity of Care Form

Anthem BlueCross BlueShield

Instructions

Only complete this form if you are receiving ongoing care, or are scheduled to receive care, from a provider that does not participate in Anthem Blue Cross and Blue Shield's (Anthem) network. 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 1-303-764-7030.

In Colorado: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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:

1. **You currently need a referral to an in- or out-of-network specialist.**
2. **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
3. **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.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(711 :TDD/TTY)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.