State and School Employees' Health Insurance Plan
Self-Insured by the State of Mississippi

Motivating Mississippi - Keys to Living Healthy

CONTINUITY OF CARE REQUEST FORM

Continuity of Care may be available to Participants receiving certain medical services from a physician, hospital or other healthcare provider when the termination of certain contractual relationships results in a change in the Provider's Network status. Participants who qualify for Continuity of Care are provided a period of up to 90 days to continue to be treated by their current Provider while transitioning to a new Network Provider.

Participant/Patient Information

Participant Name		Participant ID Number	Group Number
Home/Mobile Phone (circle which)	Work Phone	Email	
Patient's Name	Patient's Birth Date (mm/dd/yyyy)	Relationship to Participant □ Spouse □ Dependent □ Self	
Street Address	City	State	Zip

Provider Information (to be filled out by Provider)

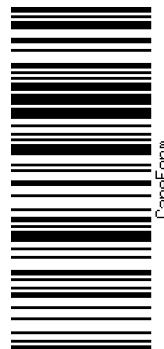
Provider Name	Provider Specialty	Individual NPI
Clinic/Practice Name		Provider Phone #
Provider Address		
Is the patient pregnant? □Yes □ No	If yes, when is the due date? _________________(mm/dd/yyyy)	
Medical condition for continuity of care consideration:		
Date Treatment Started:	Date of Next Appointment/Treatment:	How often do you see this Provider?
Diagnosis Code(s) (ICD-10):	Procedure Code(s) (CPT/HCPS):	
Participants 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 the Continuity of Care request.		

Hospital Where Provider Practices / Hospital Where Patient is Receiving Services			Hospital Phone #
Hospital Address	City	State	Zip
Date(s) of Hospital Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery	

I certify this information is complete and correct to the best of my knowledge. I hereby authorize the above healthcare provider to give Keystone Peer Review Organization (Kepro), the Plan's Medical Case Management Utilization Review vendor, any and all information and medical records, including substance use disorder records, if applicable, necessary to make a decision regarding this request for Continuity of Care.

I understand that Continuity of Care is considered individually at the discretion of the Plan's Medical Case Management Utilization Review vendor, and is only for treatment of the specific illness or condition(s) and cannot be applied to any other illnesses or condition(s). Benefits are subject to the contractual limitations and exclusions set forth in the Participant's Health and Wellness Benefit Plan. Approval of Continuity of Care does not extend the contractual benefits in any way except to provide Network level Benefits for a Non-Network Provider for a temporary time period.

Signature of Patient if 18 or older or Parent or Guardian if Patient is under age 18	Date (mm/dd/yyyy)



Continuity of Care Explanations and Instructions for Completing the Request Form

If your treating healthcare provider or facility leaves or is terminated from the Advanced Health Systems, Inc. State Network, you and/or your covered dependent(s) may be able to continue receiving care at Network levels for certain medical conditions. Continuity of Care may be provided up to 90 days. The Continuity of Care period will begin on the date of the provider's or facility's Network termination and will end either 90 days from the date of termination or when you and/or your dependent are no longer a continuing care patient, whichever is earlier.

Continuity of Care may be available if you and/or your dependent are patients of a terminating healthcare provider or facility and are:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Scheduled to undergo non-elective surgery, including post-operative care
- Pregnant and undergoing a course of treatment for the pregnancy
- Terminally ill

To qualify for Continuity of Care, you must be receiving treatment from the provider or facility for the condition identified on the request form on the date of the provider's or facility's termination.

Examples of medical conditions that may qualify for Continuity of Care include, but are not limited to:

- Cancer, either newly diagnosed or cancer in the midst of chemotherapy, radiation or reconstruction
- Candidates for organ transplant or recipients being monitored due to instability or complications
- Hospital inpatient care
- Unstable chronic conditions
- Receiving dialysis treatment
- Non-elective surgery, including post-operative care
- Recent non-elective surgeries still in the post-operative period
- Pregnancy
- Acute mental health and substance use disorder conditions in active treatment

Examples of medical conditions that do not qualify for Continuity of Care include, but are not limited to:

- Elective surgeries
- Colds, sinus infections, sore throats and other minor illnesses
- Stable and controlled chronic conditions such as diabetes, arthritis, allergies, hypertension, COPD/emphysema and asthma
- Routine exams and preventive services

If you choose to continue care beyond the time period approved by the Plan's Medical Case Management Utilization Review vendor, covered services will be provided according to the Benefit Plan's out-of-network provisions.

Continuity of Care applies only to the treatment of the condition specified and the healthcare provider or facility identified on the request form. Unrelated conditions must be cared for by an in-network healthcare provider or facility in order for you to receive Network Benefits.

Continuity of Care will not be approved if:

- Your Provider was terminated from the Network because your Provider's license to practice was revoked or suspended or for another documented reason related to quality of care
- Your Provider was terminated from the Network because of fraud
- You choose to change Providers
- You do not meet the health conditions listed on this form to qualify for Continuity of Care

All questions must be completely answered. If you fail to answer any question(s), Continuity of Care may be delayed or denied. Information is required from both you and your Provider.

If you and/or your covered dependents are seeking Continuity of Care for more than one condition, a separate Continuity of Care form must be submitted for each person and each condition.

The request form must be signed by the patient seeking Continuity of Care. If the patient is a minor, a parent or guardian's signature will be required.

Please return the Continuity of Care request form as soon as possible but no later than 30 days after the date of the notification letter. Failure to do so may lead to a delay in Continuity of Care determination and implementation.

Submit this request form to:
Blue Cross & Blue Shield of Mississippi
3545 Lakeland Drive
Flowood, MS 39232
Phone: 1-800-709-7881
Fax: 844-472-0592

Claims Administered by:

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.