



MASSACHUSETTS

CONTINUITY/TRANSITION OF CARE REQUEST FORM

Use the attached form to submit Continuity/Transition of Care requests within 90 days of your transition needs.

We offer eligible members temporary, continued coverage, when undergoing active treatment from a doctor who is no longer part of your plan's network. If coverage is approved, you're able complete your course of treatment or safely transfer to an in-network doctor or facility.

YOU MAY BE ELIGIBLE IF:*



You're a new Blue Cross Blue Shield of Massachusetts member, and your plan's treating provider isn't part of your network



Your continuity of care is at risk for reasons beyond your control, such as when your doctor leaves your plan's network

WHEN YOU SHOULD REQUEST CONTINUITY/TRANSITION OF CARE

You may submit a request for temporary continued coverage if you:

- Are in active course of treatment for an acute medical condition; a serious, chronic condition; cancer or chemotherapy; allergies; or a mental health condition
- Are pregnant, regardless of trimester
- Have a terminal illness
- Have a surgery or other procedure that has been authorized under your previous plan and is scheduled to occur within 90 days of your new plan's effective date
- Are enrolled in a cardiac rehab program that's already in progress
- Have established care with a specialist treating your acute or serious chronic condition



NEED TO FIND A DOCTOR?

If you need ongoing care for a chronic condition but aren't in an active course of treatment, visit an in-network doctor for covered care that meets your needs. Use our **Find a Doctor & Estimate Costs** tool to find the right provider for you.

To start searching, sign in to MyBlue at bluecrossma.org, then select **Find a Doctor & Estimate Costs**.

How to Submit Your Request

Complete the attached form, then submit it by fax or mail to Blue Cross using the address listed at the bottom of the form. Please allow two weeks for us to complete the review.

*Members who have elected to make changes in their coverage that cause them to be out-of-network aren't eligible for this request.

CONTINUITY/TRANSITION OF CARE REQUEST FORM

Once we've received your medical records and completed our review, we'll contact you and your doctor with the results. Please allow two weeks for us to complete this review.

Choose Your Type of Request



Transition of Care

Who Should Apply: New Blue Cross members who are receiving ongoing treatment from a provider who isn't part of the Blue Cross network

If Approved: You receive temporary, uninterrupted coverage for up to 90 days from your plan's effective date.



Continuity of Care

Who Should Apply: Members who are receiving ongoing treatment from a provider who has recently left the Blue Cross network

If Approved: You receive temporary, uninterrupted coverage for a defined period of time.



Continuity of Care (for members enrolled in a tiered plan)

Who Should Apply: Members using a tiered provider network, who are receiving ongoing treatment from a provider who has moved to the highest cost-sharing tier

If Approved: You receive temporary, uninterrupted coverage at a lower-cost tier for a defined period of time.

Please note: 1. Continuity of Care request forms require the treating provider's signature.
2. If your request is approved and we already processed related claims, those claims may require adjustments. That could result in changes to your financial responsibility, and you may need to refund a payment previously issued to you.

Subscriber Information

Last Name	First Name	Middle Initial	Date of Birth ____/____/____	
Address - Number and Street		City	State	ZIP Code
Plan Effective Date		Blue Cross Member ID #		

Patient Information

Last Name	First Name	Middle Initial	Date of Birth ____/____/____	
Address (if different than subscriber)		City	State	ZIP Code
Preferred Contact #	<input type="checkbox"/> Home Phone #	<input type="checkbox"/> Work Phone #	<input type="checkbox"/> Cell Phone #	

Do you have a primary care provider (PCP)? Yes No

If yes, please list your PCP's name:

Do you give us permission to contact your PCP with the results of this request? Yes No

PCP Phone #:

TREATMENT INFORMATION

In the following fields, please list information for the patient and treating provider(s), and describe the care plan for the treatment(s) that you would like to be considered in this request. You may include information for more than one treatment in this request.

Treatment #1			
Provider Name		Specialty	
Provider Address		City	State ZIP Code
Provider Phone #	NPI #	Date Treatment Began ____/____/____	Date of Last Appointment ____/____/____
Date of Next Appointment ____/____/____	Length of Treatment		Expected Number of Visits
Treatment Plan Description			
Provider Signature (required for Continuity of Care requests)			
Facility Name (if applicable)			
Facility Address		City	State ZIP Code
Facility Phone #		NPI #	

Treatment #2 (Optional)			
Provider Name		Specialty	
Provider Address		City	State ZIP Code
Provider Phone #	NPI #	Date Treatment Began ____/____/____	Date of Last Appointment ____/____/____
Date of Next Appointment ____/____/____	Length of Treatment		Expected Number of Visits
Treatment Plan Description			
Provider Signature (required for Continuity of Care requests)			
Facility Name (if applicable)			
Facility Address		City	State ZIP Code
Facility Phone #		NPI #	

Treatment #3 (Optional)

Provider Name		Specialty	
Provider Address		City	State ZIP Code
Provider Phone #	NPI #	Date Treatment Began ____/____/____	Date of Last Appointment ____/____/____
Date of Next Appointment ____/____/____	Length of Treatment		Expected Number of Visits
Treatment Plan Description			
Provider Signature (required for Continuity of Care requests)			
Facility Name (if applicable)			
Facility Address		City	State ZIP Code
Facility Phone #		NPI #	

Member Authorization

I hereby authorize the above provider to give the Blue Cross Blue Shield of Massachusetts Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Continuity/Transition of Care. I understand that Blue Cross Blue Shield of Massachusetts Care Management may share information and discuss my care with my Primary Care Provider/Medical Group under my plan. I understand that I am entitled to a copy of this authorization form.

I also authorize Blue Cross Blue Shield of Massachusetts to leave confidential information on my voice mail at the number(s) listed above, unless I specify otherwise below.

Please check all that apply:

Home Cell Work Do NOT leave confidential information on my voice mail.

Signature of Patient If 18 or Over

Date of Birth

____/____/____

Signature of Parent or Guardian If Patient Is Under 18

Date

____/____/____

Please complete this form in its entirety and mail or fax it to the address or appropriate number.

Mail to: Blue Cross and Blue Shield of Massachusetts
Attn: Health and Medical Management,
Clinical Intake Transition of Care
One Enterprise Drive, M/S 02/05
Quincy, MA 02171-2126

Fax to: 1-888-282-0780
(medical and surgical requests)
Fax to: 1-888-641-5199
(behavioral health requests)

Questions?

If you have questions about completing this form,
please call Member Service at the number on your ID card.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).