



REQUEST FOR CONTINUITY OF CARE SERVICE

**Complete all sections and return this signed form and a copy of your enrollment form
(when your enrollment form is not submitted to Blue Shield electronically) to:**

**Blue Shield of California
P.O. Box 272540, Chico, CA 95927-2540
1-800-424-6521**

1 Employer & Employee Identification

Effective Date on the Plan: _____
Group # _____

Employee Name _____ Member ID # _____
Employee Date of Birth ____/____/____ Day Time Phone # () _____
Mailing Address _____ City _____
State, Zip Code _____ Home Phone # () _____
Employer Name _____
Employer Address _____

2 Patient Primary Care Identification

Patient Name _____ Date of Birth ____/____/____
Relationship to Employee: Self Spouse Child
Patient's Day Time Phone () _____
Name of Patient's Blue Shield
Personal Physician _____ Phone: () _____
Name of Patient's Medical Group _____

3 Prior Health Plan Coverage Information

Name of health plan prior to Blue Shield _____
Prior Health Plan identification number _____
Was your prior health care coverage HMO? Yes No
If Yes, the IPA/Medical Group Name _____
Was your prior health care coverage PPO? Yes No
Is the patient currently covered by a second health plan? Yes No
If Yes, health plan identification number _____
Name of health plan _____
Address of health plan _____
Phone: () _____

4 Medical Information

Name and address of current attending physician or specialist: _____

Attending Physician's Phone () _____ Fax () _____

Condition or Diagnosis being treated: _____

Is patient hospitalized now? Yes No

List name of Hospital patient admitted to _____

Is the patient receiving home health care? Yes No

Is patient on Medical Leave of Absence (LOA)? Yes No Or on Medical Disability? Yes No

Type of care and frequency of care with physician(s) listed in beginning of Part 4:

If maternity, expected date of delivery _____

Name of hospital where you are planning on delivering _____

5 Additional Information You Wish To Be Considered

6 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, health care 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.

Subscriber Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

For quicker processing, please attach a copy of your Blue Shield Enrollment form.

Blue Shield Office use only: Sales Representative Name: _____ Phone: _____
Service Representative Name: _____ Ext. _____
Employer Group Number: _____ Health Plan Effective Date: _____
IPA/Medical Group Name: _____