Request for Continuity of Care Service for New Access+ HMO Enrollees

Please complete all sections and return this signed form with a copy of your Blue Shield enrollment form (when enrollment is not submitted electronically) to: Blue Shield of California, P.O. Box 272540, Chico, CA, 95927-2540, (888) 235-1765

Section 1 – Employer and employee identification

Employee name		Date of birth (mo/day/yr)	Member ID number	
Effective date on the plan Group number		Day time phone number ( )	Home phone number ( )	
Mailing address	City		State	ZIP
Employer name		Employer address		

Section 2 – Patient identification

Patient's name	Date of birth (mo/day/yr)	Relationship to subscriber ☐ Self ☐ Child ☐ Spouse/domestic partner
Daytime phone number ( )		
Name of patient's Blue Shield HMO Personal Physician	Physician's phone number ( )	
Name of patient's IPA/medical group		

Section 3 – Prior health plan coverage information

Name of health plan prior to Blue Shield	
Prior health plan identification number	Subscriber name
Was your prior healthcare coverage HMO? ☐ Yes ☐ No	If yes, name of the group
Was your prior healthcare 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 number ( )

(see reverse)

Blue Shield of California is an independent member of the Blue Shield Association C13095-540-CR-HDIEET (5/14)

Section 4 – Medical information

Name and address of current attending physician, specialist, or midwife

Attending physician's phone number ( )	Fax number ( )

Condition or diagnosis being treated

Is patient hospitalized now? ☐ Yes ☐ No	If Yes, name and address of hospital
Is patient on medical leave of absence (LOA)? ☐ Yes ☐ No	On medical disability? ☐ Yes ☐ No
Are you requesting continued care for a child who is newborn to 36 months of age? ☐ Yes ☐ No	
Is the patient scheduled for medical treatment on either an inpatient or outpatient basis? ☐ Yes ☐ No	

If Yes, provide the scheduled date, name of physician/hospital, and describe planned treatment

Is the patient currently receiving home health or hospice care? ☐ Yes ☐ No	If Yes, name and address of the home healthcare agency or hospice provider
Does the patient have a terminal condition? ☐ Yes ☐ No	
Is the patient pregnant? ☐ Yes ☐ No	If Yes, what is the expected date of delivery?

Name and address of hospital

Is the patient currently receiving home medical equipment? ☐ Yes ☐ No	If Yes, name and address of the home medical equipment provider

Section 5 – Additional information to be considered

Section 6 – 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, 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 _____

To assist us in processing your request, please attach a copy of your Blue Shield enrollment form.

Blue Shield office use Only

Sales representative name	Phone number
Service representative name	Extension
Employer group number	Health plan effective date
IPA/medical group number	