BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Continuity of Care Request Form

Member Information

Member Name		Member ID Number	Date of Birth
Home/Mobile Phone (circle which)	Work Phone	Email	
Street Address	City	State	Zip

I am a new member to BCBSVT and: Select from one of the qualifying conditions below

- o I have a chronic medical, mental health, or substance use disorder for which I have been actively seeking care with a provider who is not in my network.

  Name of Condition: _____ Is condition life threatening, disabling, or degenerative: □ Yes □ No

- o I have previously received approval from a prior insurance carrier for an upcoming scheduled service

  Date of Scheduled Service _____/_____/_____

- o I am receiving pregnancy care. Expected Due Date _____/_____/_____

OR

I am an existing member of BCBSVT and was sent a notification that a provider I'm seeing is no longer in my network

- o Name of Condition: _____ Is condition life threatening, disabling, or degenerative: □ Yes □ No
- o I am receiving pregnancy care. Expected Due Date _____/_____/_____

Provider Information

Provider Name	Provider Specialty	Individual NPI
Clinic/Practice Name		Provider Phone #
Provider Address		
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):	
Facility Where Provider Practices / Facility Where Patient is Receiving Services		Facility NPI #
Facility Address	City	State / Zip
Date(s) of Inpatient Admission (mm/dd/yyyy)	**OR**	Date of Outpatient Surgery:(mm/dd/yyyy) / Outpatient Surgery type:

For all other circumstances, please speak to your provider or contact our customer service team at the number listed on the back of your ID card to learn how to submit a request for prior approval.

I hereby authorize Blue Cross and Blue Shield of Vermont (BCBSVT), its subsidiaries, employees, officers, and agents to use the information set out above or in any attachments hereto to contact my provider(s) on my behalf in order to obtain the necessary information to manage and determine my health benefits and to discuss clinical information related to the coordination of my health care.

I authorize my health care provider(s) to provide BCBSVT with all the information and records, which could be given to me upon request. This may include medical or mental health information, and information related to treatment for alcohol or drug abuse and/or sexually transmitted disease(s).

The purpose of providing this information to BCBSVT is to coordinate my health care and determine health care benefits.
I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. However, BCBSVT and my provider(s) are obligated to protect my protected health information consistent with state and federal laws.
Unless revoked, this authorization is valid from the date of my signature until the date I am no longer insured by BCBSVT or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.

This authorization shall terminate on (specify date, if applicable) _____.

I understand that I may revoke this authorization at any time by mailing written notice of my revocation to BCBSVT, ATTN: Privacy Officer, PO Box 186, Montpelier, VT 05601. I understand that revocation of this authorization will not affect any action BCBSVT, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts Inc. and Vermont Collaborative Care, LLC took in reliance on this authorization before it received my written notice of revocation.

Signature of Patient: _____ Date: _____/_____/_____ (if patient is age 12 or older)
Signature of Parent/Guardian: _____ Date: _____/_____/_____ (if patient is under age 12)

Please return this completed Continuity of Care Request form with supporting clinical to:

Mail
BCBSVT Utilization Management
P.O. Box 186
Montpelier, VT 05601

Fax
(866) 387-7914

Upon receipt of this form and once membership is active (if you are not currently a member), you will receive notification in writing relating to your request. If upon review of your form, it is determined that you may benefit from one of our chronic care, maternity wellness, or case management programs, we may contact you by phone.