

Continuity of Care Request Form

Continuity of Care requests applies to large group, small group and individual plan enrollees. If you are currently receiving treatment and are (a) a new SHP member or (b) an existing SHP member whose physician is leaving or has left the SHP network, you may request to temporarily remain with your current treating physician. Please see the back of this form for more information about what “continuity of care” is and whether you may be eligible. To request continuity of care, complete this form for each physician you want to retain. Return the completed form to SHP within 30 days of your effective enrollment date (if new) or within 30 days of the date your physician left the SHP network. SHP will notify you if you qualify for continuity of care.

IMPORTANT NOTE: Continuity of care does not apply to a new member who had the option to continue coverage with his or her previous health plan or provider (including through an out-of-network option) and who instead voluntarily changed health plans.

Section 1: Patient Information			
Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Diagnosis:		DOB:	
Street Address:		Relationship to Subscriber:	
City:	State:	Zip Code	
Section 2: Subscriber Information			
Subscriber ID # (If already enrolled):		SHP Effective Date:	
Last Name:	First Name:	MI:	
Street Address:			
City:	State:	Zip	
Home Phone:	Work Phone:	Mobile Phone:	
Employer:	Email Address		
Name of Previous Health Insurance Carrier:			
HMO:		PPO:	
Is SHP the only insurance plan offered to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you voluntarily change health plans? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 3: Current Provider/Specialist Information

(*If Continuity of Care is needed for more than one specialist please check here _____ and list additional specialists/providers with address and treatment information on the back of this form.)

Current Medical Group:	Specialist Providing Treatment:	
Type of Specialty:	Specialist's Phone Number:	
Specialist Street Address		
City:	State:	Zip Code

Section 4: Diagnosis Questionnaire

1.	Is this patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>*If No, Skip to Question #2 below.</i> a.) Expected Due Date: _____ b.) Name of OB/GYN Provider: _____ c.) Name of Hospital in which Patient wishes to deliver: _____
2.	Diagnosis
3.	Is the patient currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Date treatment started
5.	Date of next scheduled treatment/appointment:
6.	Current treatment/need (briefly describe):

I authorize the medical providers listed above to disclose all medical records to Sutter Health Plus (SHP) for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after SHP completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and SHP are required under state and federal law to keep my medical information confidential. I understand that SHP will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

Signature Patient or Parent/Guardian (if patient is a Minor Child)

Date

Please return this completed form to:

Sutter Health Plan
P.O. Box 160305
Sacramento, CA 95816
Fax (916) 736-5421 or toll-free fax 1 (855) 759-8752
sutterhealthplus.org

WHAT IS CONTINUITY OF CARE?

In certain circumstances (described below), you may temporarily continue care with a physician who is not part of SHP's network (a "Non- Participating Provider"). If you are being treated by a provider who has been terminated from SHP's network, or if you are a new Member who has been receiving care from a Non-Participating Provider, you may continue care with that provider if you meet the continuity of care requirements explained below.

CONTINUITY OF CARE REQUIREMENTS

In order for you to be eligible for continued care, the Non-Participating Provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by SHP's VP Care Management on a case-by-case basis.

- An acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition: a serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by SHP in consultation with the member and the terminated provider or Non-Participating Provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled member.
- A pregnancy. Care will be continued for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness. An incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and thirty-six (36) months. Care shall be continued for up to twelve (12) months from contract termination of provider or from effective date of coverage for a newly covered Member.
- Performance of surgery or other procedure that has been authorized by SHP (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days of the provider's termination date or the effective date of coverage for a new Member.

IMPORTANT EXCEPTIONS

Provider Requirements: SHP and/or the medical group will require the Non-Participating Provider to agree to SHP's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not agree to these contractual terms and conditions, you will not be eligible to continue care with that provider. A terminating Participating Provider will be compensated pursuant to the terms of the terminated provider agreement for the statutorily required period of time when such arrangements are specified in the particular Participating Provider Contract.

A Non-Participating Provider and a provider whose terminated contract does not specify that compensation for COC services will be compensated under the terms of the terminated contract, will be compensated at the same rate that is paid to similar Participating Providers that are non-capitated providers for similar services in the same geographic region, unless otherwise agreed by the Plan and the Non-Participating Provider.

Neither SHP nor the Participating Medical Group is required to continue the provider's services if the Non-Participating provider or Terminated Provider does not agree to comply or does not comply with the contractual terms and conditions as to similarly situated providers as described above.

Member/Subscriber Voluntary Change in Coverage: Continuity of care does not apply to a new member who had the option to continue with his or her previous health plan or provider (including through an out-of-network option), and instead voluntarily changed health plans.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sutter Health Plus Member Services (855) 315-5800. (English)

IMPORTANTE: ¿Puede leer esta carta? Si no puede, podemos pedir que alguien le ayude a leerla. También es posible obtener esta carta en su idioma. Para recibir ayuda gratuita, llame enseguida al departamento de Servicio a los miembros de Sutter Health Plus al (855) 315-5800. (Spanish/ Español)