Scripps

Scripps Health Plan UM
Fax: 858-260-5877

CONTINUITY OF CARE REQUEST FORM

We understand that you may be obtaining care from a provider who is not contracted with Scripps Health Plan. If you feel you have a special situation such that your care could not be transferred to a Scripps Health Plan provider on the date of change in your plan, or enrollment date with Scripps Health Plan, you may request that Scripps Health Plan review your special situation. Under certain circumstances, you are entitled to continuation of care with a non-contracted provider.

To request a continuation of care review, please provide the information below as completely and accurately as possible to avoid delay in processing your request. You or your authorized representative may complete the form. If possible, please complete Section 1 on the reverse side of the form, and then provide this form to your provider to complete Section 2 to assist us in processing your request for continuation of care.

Member's name:	Subscriber's ID #:
Subscriber's name:	Member's date of birth:
Employer Group:	Please check one: □ HMO
Member's address:	
Member's telephone # (work):	Member's telephone # (home):
Preferred # to call from 8:00 a.m. to 5:00 p.m.:	
From:	
Medical group/Insurance co:	Phone #:
Primary care physician:	Phone #:
To:	
Medical group/Insurance co:	Phone #:
Primary care physician:	Phone #:
Current diagnosis/condition description:	Current treatment(s):
Reason(s) for requesting assistance (please check all that apply)	
My medical need(s) is/are (please check all that apply)	
☐ Surgery	☐ Pregnancy and immediate postpartum
☐ Surgical follow-up	☐ Care of newborn
☐ Scheduled procedures/surgery	☐ Chemotherapy
☐ Serious chronic condition	☐ Radiation
☐ Terminal illness	☐ Transplant
☐ Specialist Office Visit	☐ Behavioral/Mental Health Services
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Date of scheduled appointment:	Authorization # if available:
Authorized by:	
Other special needs/comments	

Attach another page for other additional information as needed.

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Member signature:	Date:
If filled out by other than the member:	
Name of requestor:	Relation to member:
Phone #:	Date:

Section 1 - Patient information (to be completed by the Scripps Health Plan Member)

If possible, please complete the front side of this form along with the Section 1 below and ask your provider to complete Section 2. This is not required but will expedite the review of your request.

Subscriber name:	Scripps Health Plan ID:
Patient name:	Date of Birth:
Address:	
Non-network treating provider signature:	Phone #:

Please Note: your provider may require you to complete an Authorization for Release of Information.

Section 2 - Provider information (to be completed by the provider)

Your patient has requested that Scripps Health Plan cover care provided by you for a specific diagnosis and period of time. If you agree to continue to see your patient and accept Scripps Health Plan's standard rates, please provide the requested information so that we can evaluate your patient's request. If you are not willing to accept Scripps Health Plan's standard rates, please indicate so below.

Please check one option: ☐ Agree to continue to see your patient accepting Scripps Health Plan rates ☐ Not willing to continue to see your patient. You may skip section below	
Diagnosis:	ICD code(s):
Expected duration of transition:	
Treatment/treatment plan:	
Treatment/surgical date:	For pregnancies, EDC:
CPT code(s):	
Non-network treating provider name (print):	Phone #:
Tax ID #:	NPI #
Non-network treating provider signature:	Date:

Fax completed form and any supporting documentation you believe is appropriate to: 858-260-5877

Scripps Health Plan may contact you at the number provided above for additional information or to resolve your patient's request. Each case is reviewed with guidelines and criteria in place.

Please note that filling out the Continuation of Care form does not guarantee requested services will be covered.