Scripps | Scripps Health Plan

CONTINUITY OF CARE REQUEST FORM

Scripps Health Plan
Fax: 858-964-3102

STEP 1: Fill out these sections:

1. Section 1 – Employer Information
2. Section 2 – Subscriber and Patient Information (Refer to the front of the member ID card.)
3. Section 3 – Authorization (Read the authorization, then sign and date the form.)

STEP 2: Give the form to the doctor/health care provider to complete Section 4.
STEP 3: **Fax** the completed form to Scripps Health Plan for review.

Once we receive your completed form, we'll send you a letter explaining our decision. If we approve your request, Scripps Health Plan (SHP) will cover ongoing care at the highest level of benefits from:

- An **out of network doctor willing to accept SHP's contracted rates**
- **Certain other health care providers** who have treated you

Q. What is continuity of care (COC) coverage?
A. It is the policy of SHP to provide continuity of care for new enrollees who are undergoing an active course of treatment from a nonparticipating provider. SHP has established policies and procedures for the safe planned and unplanned transfer of care of new members with acute, serious chronic medical and/or mental health conditions who are currently receiving services from a nonparticipating medical and/or mental health provider to a participating provider when his/her employer changes health plans. Approved COC coverage allows a member who is receiving treatment to continue treatment **for a limited time** at the highest plan benefits level. COC coverage applies to these types of providers: medical and mental health providers, general and specialty practitioners, hospitals, and institutions licensed in California to deliver or furnish health care services.

Q. What is an active course of treatment?
A. An active course of treatment means you have begun a program of planned service with your doctor to correct or treat a diagnosed condition. To be considered for COC coverage, treatment must have started before the enrollment date. The start date is the first date of service or treatment. An active course of treatment covers a certain number of services or period of treatment for special situations. Any newly enrolled plan member that is in a course of treatment or is scheduled for a procedure can request to continue treatment with that provider for the following covered services:

- An Acute Condition – Completion of covered services shall be provided for the duration of the acute condition.
- A Serious Chronic Condition – Completion of covered services shall not exceed 12 months from the date of enrollment in SHP.
- A Pregnancy – Completion of covered services shall be provided for the duration of the pregnancy.
- A Maternal Mental Health Condition – Completion of covered services shall not exceed 12 months from diagnoses or from the end of pregnancy, whichever occurs later.
- Care of a Newborn Child (0-36 months) – Completion of covered services shall not exceed 12 months from the date of enrollment in SHP.
- Performance of a Surgery by a Non-Contracting Provider – Covered if the procedure is scheduled within the first 180 days of enrollment in SHP.
- A Terminal Illness – Completion of covered services shall be provided for the duration of a terminal illness.
- A Mental Health Condition – The member shall be allowed a reasonable transition period to continue his or her course of treatment with a non-contracted provider.

Q. What other types of providers, besides doctors, can be considered for COC coverage?
A. COC coverage may also apply to physical/occupational/speech therapists, and agencies that provide skilled home care services, such as visiting nurses. Providers considered for COC coverage may vary by condition, as described above, in accordance with California law. California COC coverage does not apply to durable medical equipment (DME) vendors or pharmacy vendors.

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

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1. Employer Information

Employer's Name (please print)	Employer Group Number	Plan effective date (required)

2. Subscriber and Patient Information

Subscriber's Name (please print)		Member ID Number	
Subscriber's Address	City	State	Zip
Patient's Name – *if different from Subscriber* (please print)	Relationship to Subscriber □Spouse □Child □Other	Sex	Date of Birth / /
Patient's Address – *if different from Subscriber*	City	State	Zip
Telephone number for Patient/Subscriber submitting request	Last date of treatment before beginning Scripps Health Plan coverage (as applicable)		

3. Authorization

MEMBER DISCLAIMER/AUTHORIZATION

I request approval for coverage of ongoing care from the healthcare provider named below for treatment started before my effective date with Scripps Health Plan. **If approved**, I understand that the authorization for coverage of services stated below will be valid for a **certain limited period of time**. I give permission for the healthcare provider to send any needed medical information and/or records to Scripps Health Plan so a decision can be made.

Patient's Signature (required if Patient is 17 or Older)	Date (MM/DD/YYYY)
Parent's Signature (required if Patient is 16 or Younger)	Date (MM/DD/YYYY)

4. Provider Information – *This section to be completed by your physician.*

Your patient has requested that Scripps Health Plan cover care provided by you for a specific diagnosis and period of time. Scripps Health Plan may contact you at the number provided below for additional information or to resolve your patient's request. Each case is reviewed with guidelines and criteria in place. If this COC request is approved, Scripps Health Plan will contact your office to discuss contracted rates.

Name of treating doctor or other health care provider (please print)	Telephone Number
Contact name of office personnel to call with questions	Business Hours
Address of treating doctor or other health care provider (please print)	Tax ID Number
Signature of treating doctor or other health care provider	Date (MM/DD/YYYY)

Please provide all specific information to avoid delay in processing this request, including, but not limited to: - CPT code(s) - Diagnosis code(s) - Expected duration of treatment - Treatment plan - Surgical Date - For pregnancy, expected delivery date	**Fax completed form and any supporting documentation you believe is appropriate to: 858-964-3102**

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