Scripps | Scripps Health Plan

Scripps Health Plan
Fax: 858-964-3102

CONTINUITY OF CARE (COC) REQUEST FORM

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 treating physician/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 in accordance with state and federal guidelines for members currently receiving a course of treatment from a terminated provider and for new members who are undergoing an active course of treatment from a non-participating provider. SHP has established policies and procedures for the safe planned and unplanned transfer of care of members with qualifying conditions who are currently receiving services from a non-participating medical and/or mental health provider to a participating provider. Approved COC coverage allows a member who is receiving treatment from a non-participating provider to continue treatment with that provider 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 treat a diagnosed condition. To be considered for COC coverage, treatment must have started before the enrollment and/or provider termination 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 qualifying conditions, which include:

- An Acute Condition – Completion of covered services shall be provided for the duration of the acute condition,
- A Serious Chronic and/or Complex Medical Condition – Completion of covered services shall be provided for the time period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with the Member and the terminated/non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan,
- 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 the diagnosis or from the end of pregnancy, whichever occurs later,
- Care of a Newborn Child Between Birth and Age 36 Months - Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan,
- Performance of a Surgery or Other Procedure (Including Postoperative Care) – Authorized by the Plan as part of a documented course of treatment and has been recommended and documented by the non-contracting provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage with the Plan,
- Inpatient or Institutional Treatment – Completion of covered services shall last the earlier of 90 days from the date the notice of the right to elect continuing care is provided to the Member or the date on which the Member is no longer undergoing continuing care by that provider or facility,
- A Terminal Illness – Completion of covered services shall be provided for the duration of a terminal illness, which

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

may exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan.

If a condition falls within a qualifying condition under state and federal law, the more generous time frames would be followed.

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 state and federal law.

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

Scripps | Scripps Health Plan

Scripps Health Plan
Fax: 858-964-3102

CONTINUITY OF CARE (COC) REQUEST FORM

Section 1: Employer Information			
Employer Name	Employer Group Number	Plan Effective Date (required)	
Section 2: Subscriber Information			
Subscriber Name		Member ID Number	
Address	City	State	Zip
Telephone Number	Prior Insurance	Prior Medical Group	
Patient Information			
Patient Name (if different than Subscriber)	Relationship to Subscriber □Spouse □Child □Other	Sex	Date of Birth
Address (if different than Subscriber)	City	State	Zip
Telephone Number (if different than Subscriber)	Last treatment date before beginning Scripps Health Plan coverage (as applicable)		
Section 3: 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)	
Section 4: Treating Physician/Provider Information - *This section to be completed by your treating physician/provider.*			
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.			
Treating Physician/Provider Name	Telephone Number	Specialty	
Address		Tax ID Number	
Contact name of office personnel to call with questions		Business Hours	
Diagnosis Code(s):			
CPT Code(s):			
Expected Treatment Duration:			
Treatment Plan:			
Pregnancy (Expected Delivery Date):	Hospital: (if applicable)		
Surgery/Procedure: (if applicable)	Surgical Date: (if applicable)		
Signature of Treating Physician/Provider:		Date (MM/DD/YYYY):	

Fax completed form and supporting clinical documentation to Scripps Health Plan 858-964-3102

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