Continuity of Care

REQUEST FORM

Mail to: 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Send it by secure fax to: 916.568.0126
Questions: 916.563.2250 or 888.563.2250 toll-free or 888.877.5378 TTY

If you are currently receiving treatment and (i) a new WHA member or (ii) an existing WHA member whose physician has terminated with WHA, you may request to temporarily remain with your existing physician. Please see the back for more information about what continuity of care is and if you may be eligible. To request continuity of care, complete this form for each physician you want to retain. If you do not have a qualified continuity of care issue, you may still request assistance in changing to WHA providers by using this form. Turn this form into WHA within 30 days of enrolling (if new) or of when your physician terminated with WHA. WHA will let you know if you qualify for continuity of care.

REQUEST FOR: ❑ Continued Care With Current Specialist ❑ Assistance With Changing Specialist/Provider

Section I — EMPLOYEE AND PLAN information

Employee First Name _____ Last Name _____ MI _____

Social Security # _____ Date of Birth _____ Effective Date _____

Member ID# _____ Employer _____

Employee Address _____ Apt./Unit# _____

City, State, Zip _____ Home Phone _____

Work Phone _____ Previous Health Insurance Carrier _____ ❑ HMO ❑ PPO

Is WHA the only health insurance plan offered to you? ❑ Yes ❑ No Did you voluntarily change health insurance plans? ❑ Yes ❑ No

Section II — PATIENT, PHYSICIAN AND TREATMENT INFORMATION

Patient Name _____ Diagnosis _____

Relationship to Employee _____ Date of Birth _____ Phone _____

Address _____ Apt./Unit# _____

City, State, Zip _____

Previous Health Insurance

Primary Care Physician _____ Medical Group _____

Specialist _____ Specialty _____ Phone _____

Specialist Address _____ Suite# _____

City, State, Zip _____

Is patient pregnant? ❑ Yes ❑ No Due Date _____ OB Name _____ Delivering Hospital _____

Date of initial diagnosis/treatment _____ Is patient currently receiving treatment? ❑ Yes ❑ No

Date of next scheduled treatment/appointment _____

Current treatment/need (provide details, use separate sheet if necessary) _____

_____

_____

Section III — SIGNATURE REQUIRED

I authorize the medical providers listed above to disclose all medical records to Western Health Advantage (WHA) for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after WHA 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 WHA are required under state and federal law to keep my medical information confidential. I understand that WHA 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.

Patient Signature _____ Date _____

OFFICE USE ONLY ❑ COC, eligibility verified ❑ No COC, assistance only Approved by _____ Date _____

WHAT IS CONTINUITY OF CARE?

In certain circumstances (below), you may temporarily continue care with a physician who is not part of WHA's network (a "Non-Participating Provider"). If you are being treated by a provider who has been terminated from WHA'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 the Medical Director 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 WHA 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.
- Performance of surgery or other procedure that has been authorized by WHA (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

NOTE ABOUT PROVIDERS

WHA and/or the medical group may require the Non-Participating Provider to agree to WHA's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not comply with these contractual terms and conditions, you will not be eligible to continue care with that provider.

IMPORTANT EXCEPTION

Continuity of care does not apply to a new member who had the option to continue with the previous health plan provider (including an out-of-network option) and, instead, voluntarily changed health plans. To request a copy of Western Health Advantage's continuity of care policy, please call our Member Services Department.

IMPORTANTE: ¿Puede leer este formulario? Si no, nosotros le podemos ayudar a leerlo. Además, usted puede recibir este formulario escrito en español. Para obtener ayuda gratuita, llame ahora mismo al Western Health Advantage 888.563.2250 lunes a viernes de 8 a.m. a 6 p.m.