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Continuity of Care Request Form
for Providers Disengaging from the Network

Blue Cross Blue Shield of Massachusetts (BCBSMA*) members who are receiving services from a provider that has recently terminated their contract are eligible for continuity of care benefits in certain situations to ensure that they receive continuous, uninterrupted care for a defined period of time. The transition period allows members to either complete their course of treatment or to safely transfer their care to an in-network physician or facility. **Please complete this form for any BCBSMA member you believe is eligible for continuity of care, then:**

- Return via fax: **1-888-282-0780**, or
- Return via mail: Blue Cross Blue Shield of Massachusetts
  Attn: Clinical Coordination Transition of Care Unit
  One Enterprise Drive
  No. Quincy, MA 02171

Once we have received the appropriate medical records and completed our review, we will contact you to let you know whether these services from a non-participating provider will be covered for the identified member.

BCBSMA Member Information

Member Name: _____ DOB: _____

Address: _____

BCBSMA Member ID (including alpha prefix): _____

Please indicate the reason you believe the member listed above is eligible for continuity of care.
(*Please check all that apply)*

☐ The member is in her second or third trimester of pregnancy
Due date: _____

☐ The member is considered terminally ill (life expectancy <6 months)

☐ Other—describe condition and reason for requesting continuation of care
_____

Treatment Information

List those providers impacted by this termination who would not be a part of the BCBS network and who are currently treating the member listed above. Please provide the information below for each provider.

Provider name: _____ Phone #: ( ) _____

Service(s): _____

Length of treatment: _____ Expected number of visits: _____

Provider name: _____ Phone #: ( ) _____

Service(s): _____

Length of treatment: _____ Expected number of visits: _____

Name of Physician Requesting Transition of Care: (PLEASE PRINT): _____

Physician Signature: _____ Date: _____

*BCBSMA refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc. and/or Massachusetts Benefit Administrators LLC, based on Product participation