Continuity of Care Request for Plans That Include a Tiered Provider Network

If you are enrolled in one of our health plans that includes a tiered provider network, you may qualify to receive care at certain higher-cost facilities and pay a lower cost share for up to one year if your current provider is in the highest cost-sharing tier and you meet certain criteria. These plans include: Essential Blue YA, HMO Blue Options^{SM}, HMO Blue New England Options^{SM}, Preferred Blue PPO^{SM} Options, and plans with the Hospital Choice Cost Sharing feature.

Please complete this form if you would like Blue Cross Blue Shield of Massachusetts to review your information and determine if you qualify for this protection.

Member Information

Member Name: ______________________________ Date of Birth: ____________________

Member Address: ____

Blue Cross Blue Shield of Massachusetts Identification Number: ____________________

Home Phone Number: ____________________ Work Phone Number: ____________________

Treatment Information

Please list the required health care provider information below.

Facility Name: ____

Facility Address: ____

Facility Phone Number: ____

Diagnosis (What are you being treated for?): ___________________________________

Date of your next appointment (including adjustment of medications), admission, or treatment at this facility: ____

Date of last appointment (including adjustment of medications), admission, or treatment at the facility:

____

Date Treatment Began at the Facility: ____

List all tests, x-rays, scans or procedures that you require at least every 6 months as part of your treatment:

____

Physician/Clinician Name: ____

Physician/Clinician Specialty, If Known: _______________________________________

Physician/Clinician Address: ____

Physician/Clinician Phone: ____

I certify that I have answered all of the above questions truthfully and accurately and understand that providing false, misleading, or incomplete information on this application may lead to termination of coverage in the health plan or disqualification from receiving a continuity of care benefit at a lower level of cost share.

Signature: ______________________________________ Date: ____________________

Please return this form to: Blue Cross Blue Shield of Massachusetts, Inc.
PO Box 9134, North Quincy, MA 02171-9134
Attn: Correspondence Unit
You may fax to: **1-617-246-6333**

Once we have received your form and completed our review, we will contact you.

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