MASSACHUSETTS

Continuity of Care Request Form

Request Continued Care with Your Doctor at a Lower Cost

Available for plans that use a tiered provider network

You may be able to receive care at certain higher-cost facilities, and pay lower costs for services, for up to one year. In order to qualify, your plan must use a tiered provider network, your current doctor is in the highest cost-sharing tier, and you meet certain criteria.

Member Information

Subscriber Information	
Name:	Date of Birth:
Address:	
New Blue Cross Coverage Effective Date:	Blue Cross ID Number:
Patient Information	
Name:	
Primary Phone Number:	Secondary Phone Number:
Do you have a primary care provider (PCP)? square Yes square No	If yes, name:
Do we have your permission to contact your PCP with the results of this review? square Yes square No	
If we need to contact you for medical records for clinical review, which phone number do you prefer? square Primary square Secondary	

(continued)

Treatment Information

Please list the required health care provider information below.	
Facility Name:	
Facility Address:	
Facility Phone Number:	Facility National Provider Identifier (NPI) 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 this facility:	
Date treatment began at this facility:	
List all tests, X-rays, scans, or procedures that you require at least every six months as part of your treatment:	
Doctor's Name:	Doctor's Specialty, If Known:
Doctor's Address:	Doctor's Phone Number:

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'll contact you.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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