

Continuity of Care Request Form

Use this form to request approval to continue care with your current provider who is no longer in your plan’s network.

What is Continuity of Care?

There are times when you may be able to continue care with your provider who is not in Medica’s network and still receive in-network benefits. When reviewing your request, we will consider your medical, cultural and/or language needs. If your request is approved, you may receive an extension of up to 120 days or for the rest of your life if your life expectancy is 180 days or less.

Please answer all questions based on the person who needs continuity of care	
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you have a cultural need that can only be met by a provider with special expertise in that culture?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you need services from a provider who speaks a language other than English?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Are you in your second or third trimester of pregnancy?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you have a physical or mental disability?
Yes <input type="checkbox"/>	No <input type="checkbox"/> If yes, has it lasted, or can it be expected to last, for at least one year?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Does it prevent you from engaging in major life activities?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you have a terminal illness?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Are you receiving chemotherapy or radiation therapy?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you have a life-threatening mental or physical illness?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Do you have an acute (<i>brief but severe</i>) condition? If yes, what is the condition?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Have you talked with this provider about a specific condition in the past 90 days? If yes, what was the condition?
Yes <input type="checkbox"/>	No <input type="checkbox"/> Are you experiencing an acute episode related to a chronic disease? <i>Examples include: multiple sclerosis (MS), congestive heart failure, HIV/AIDS or other chronic or disabling condition(s)</i>
Yes <input type="checkbox"/>	No <input type="checkbox"/> Have you received a recent transplant or are you eligible to have a transplant?
Contact Information	
Patient Name:	Name if Filling Out on Patient’s Behalf:
Address:	Medica Group/Policy Number (from your ID card):
Date of Birth (Month / Date / Year):	Best Time to Call (Morning / Afternoon / Evening):
Phone Number:	Treatment Required and Frequency:
Current Medications:	

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Provider You are Requesting to See	
Name of Provider Requesting Coverage with:	Date of Last Visit with this Provider:
Provider Specialty:	Provider Office Address:
Provider Phone Number:	Provider Fax Number:
Additional Provider Name (<i>if needed</i>):	Date of Last Visit with this Provider:
Provider Specialty:	Provider Office Address:
Provider Phone Number:	Provider Fax Number:
Additional Provider Name (<i>if needed</i>):	Date of Last Visit with this Provider:
Provider Specialty:	Provider Office Address:
Provider Phone Number:	Provider Fax Number:

Submitting Your Form:

Please send the completed form by U.S. mail:

Medica

Mail Route CP595

PO BOX 9310

Minneapolis, MN 55440-9310

Once we receive your form, we'll review it and will send you a letter within 14 days letting you know whether your request is approved.

Have Questions?

Please call us at the number on the back of your Medica ID card.

RELEASE OF MEDICAL INFORMATION:

By signing this form, I authorize any health care professional or entity to release my medical records, including any mental health or substance abuse records, to Medica for purposes related to this request. I agree that the information I'm providing is correct.

I understand that I may revoke, in writing, this consent at any time. Otherwise, this consent will expire one year from the date of signature.

Signature of Member/Patient

Date

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Signature of Parent or Guardian
 (If patient is under age 18)

Relationship

Date

To be Completed by Your Current Treating Provider		
Member Name:	Member Group and Identification Number:	
Provider Name:	Physician Number:	Phone Number:
Address:	City:	State/Zip Code:
Date of Last Visit:	Next Scheduled Appointment:	
Diagnosis:	Frequency of Visits:	
Expected Length of Treatment:	If maternity, expected date of delivery?	
Current Treatment/Comments:		
Signature of Provider	Date	

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Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you want free help translating this document, call 1-800-952-3455.

Si desea recibir asistencia gratuita para la traducción de este documento, llame al 1-800-952-3455.

Yog koj xav tau kev pab dawb txhais daim ntwav no, hu rau 1-800-952-3455.

如果您需要我們免費幫您翻譯此文件，請致電 1-800-952-3455。

Nếu quý vị muốn giúp dịch tài liệu này miễn phí, gọi 1-800-952-3455.

Sanadnikun kaffaltiimaleeakkaisiniifhiikamuyoobarbaadd-an 1-800-952-3455 tiinbilbilaa.

إذا كنت ترغب في مساعدة مجانية لترجمة هذا المستند، فاتصل على الرقم 1-800-952-3455.

Если вы хотите получить бесплатную помощь в переводе этого документа, позвоните по телефону 1-800-952-3455.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການແປເອກະສານນີ້, ໃຫ້ໂທຫາ 1-800-952-3455.

이 문서를 번역하는 데 무료로 도움을 받고 싶으시면 1-800-952-3455로 전화하십시오.

Si vous désirez obtenir gratuitement de l'aide pour traduire ce document, appelez le 1 800 952 3455.

နမ့်လိၣ်ဘၣ်တၢ်မၤစၢၤကလိၣ်လၢတၢ်ကွဲးကျိၣ်ထံလံာ်အံၤအသိၤ,ကိး 1-800-952-3455.

Kung nais mo ng libreng tulong sa pagsasalin ng dokumentong ito, tumawag sa 1-800-952-3455.

ይህን ሰነድ ለምተርጎም ነጻ እርዳታ ከፈለጉ በ 1-800-952-3455 ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovog dokumenta, nazovite 1-800-952-3455.

T'áá jiiik'é díí naaltsoos t'áá nizaadk'ehjí bee shí ká'adoowol ninízingo kojí' hodiílnih, 1-800-952-3455.

Wenn Sie kostenlose Hilfe zur Übersetzung dieses Dokuments wünschen, rufen Sie 1-800-952-3455 an.

COMIFB-0517-K

Disclosures Pertaining to Substance Abuse Records:

Any substance abuse information about you that is received by Medica from your provider may not be re-disclosed by Medica to others except as allowed by state and federal laws and rules. In particular, federal rule 42 CFR Part 2 prohibits any further disclosure of such information unless further disclosure is permitted by your written consent or as otherwise permitted by 42 CFR Part 2.

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