Continuity of Care Request

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.

Submitting your form:

Medica
Mail Route CP555
PO BOX 9310
Minneapolis, MN 55440-9310

Or fax this form to: 952-992-3198

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.

A CONTINUITY OF CARE

Please answer all questions based on the person who needs continuity of care

Do you have a cultural need that can only be met by a provider with special expertise in that culture? ❍ Yes ❍ No

Do you need services from a provider who speaks a language other than English? ❍ Yes ❍ No

Are you in your second or third trimester of pregnancy? ❍ Yes ❍ No

Do you have a physical or mental disability? ❍ Yes ❍ No
If yes, has it lasted, or can it be expected to last, for at least one year? ❍ Yes ❍ No
Does it prevent you from engaging in major life activities? ❍ Yes ❍ No

Do you have a terminal illness? ❍ Yes ❍ No

Are you receiving chemotherapy or radiation therapy? ❍ Yes ❍ No

Do you have a life-threatening mental or physical illness? ❍ Yes ❍ No

Do you have an acute (*brief but severe*) condition? ❍ Yes ❍ No
If yes, what is the condition? _____

Have you talked with this provider about a specific condition in the past 90 days? ❍ Yes ❍ No
If yes, what was the condition? _____

Are you experiencing an acute episode related to a chronic disease? *Examples include: multiple sclerosis (MS), congestive heart failure, HIV/AIDS or other chronic or disabling condition(s)* ❍ Yes ❍ No

Have you recieved a recent transplant or are you eligible to have a transplant? ❍ Yes ❍ No

B 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/Day/Year):	Best Time to Call (Morning / Afternoon / Evening):
Phone Number:	Treatment Rrequired and Frequency:
Current Medications:	

C	PRODIVER YOU ARE REQUESTING TO SEE	
	Name of Provider Requesting Coverage:	Date of Last Visit with this Provider:
	Provider Specialty:	Provider Office Address:
	Provider Phone Number:	Provider Fax Number:
	Additional Provider Name *(if needed*):	Date of Last Visit with this Provider:
	Provider Specialty:	Provider Office Address:
	Provider Phone Number:	Provider Fax Number:
	Additional Provider Name *(if needed*):	Date of Last Visit with this Provider:
	Provider Specialty:	Provider Office Address:
	Provider Phone Number:	Provider Fax Number:

D	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:	
	Signature of Parent or Guardian (If patient is under age 18):	Relationship:	Date:

E	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:

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 information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila’a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d’identification Medica.

နမ့်ၢ်အဲၣ်ဒိးတၢ်ကျိးထံစၢၤကလီနှၤ်နၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီနှၣ်,ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနန့ၣ်ခၢၣ်ခံလၢအသးခးကွ့အလီၢ်ခံတကပၤအဖီခိၣ်နှၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዚ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t’áá jíík’e shá ata’ hodoonih nínízingo éí ninaaltsoos Medica bee néího’dílzinígí bine’déé’ námboo biká’ígíįjį’ béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

COMIFB-0119-M

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.