Continuity of Care Form

To complete this form:

- Please make sure all fields are completed.
- When the form is complete, it must be signed by the member for whom the Continuity of Care is being requested. If the patient is a minor, a guardian's signature is required.
- You are encouraged to apply for Continuity of Care within 30 days of the care provider's termination date, as noted in the letter you received.
- A separate Continuity of Care form must be completed for each condition you and/or your dependents are seeking Continuity of Care.
    - Either you or your provider can return the completed form along with relevant medical records and information by mail or fax. Whether you or your provider submits the completed form, we encourage you to obtain a copy of the completed form for your records
    - **UMR Continuity of Care**
      PO Box 8042
      Wausau, WI 54402-8042
      Fax: (855) 229-4454
- After receiving your request, we will review and evaluate the information provided. Once determination has been made, we will send you a letter to let you know if your request was approved, denied, or if the form is incomplete and no determination can be made. Completion of this form does not guarantee that a Continuity of Care request will be granted.

Patient Information - Please print clearly.			
Full Name of Person Being Treated		Member ID Number (Refer to insurance ID card)	Date of Birth (mm/dd/yyyy)
Address		City	State/ZIP Code
Home/Cell Phone Number		Work Phone Number	
Employer Name	Group ID (Refer to insurance ID card)	Patient's Relationship to Employee ☐Self ☐Spouse ☐Dependent ☐Other	
Authorization to release records: I authorize all physicians and other health care professionals or facilities to provide information concerning medical care, advice, treatment or supplies for the patient named above. This information will be used to determine the member's eligibility for Continuity of Care benefits under the plan.			
Patient Signature/Parent or Guardian's Signature if Member is a Minor			Date (mm/dd/yyyy)

Care Provider Section: Your terming physician should complete the following information. Please print clearly.			
Provider Full Name	Provider Term Date	Termed Provider Tax ID Number (TIN)	Provider Office Phone Number
Address		City	State/ZIP Code
Hospital			Hospital Phone Number
Primary Diagnosis (ICD10)		Secondary Diagnoses (ICD10)	Expected Length of Treatment (Up to 90 days from provider termination)
Date of Last Visit (mm/dd/yyyy)		Next Scheduled Appointment (mm/dd/yyyy)	If Maternity: Expected Date of Delivery (mm/dd/yyyy)

Please select 1 of the descriptions if it applies:

☐Life-Threatening Condition ☐Acute Condition ☐Transplant ☐Inpatient/Confined
☐Upcoming Surgery ☐Disabled/Disability ☐Terminal Illness ☐Ongoing Treatment

Current and Associated Treatment(s)/Comments (Include all relevant CPT codes)

We understand you are not, or soon will not be, a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable time-frame, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval before the services are rendered. Please note the following:

For providers leaving our network, the terms and conditions of your participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or co-insurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional and Title Date (mm/dd/yyyy)

Care Provider Section: Your terming facility should complete the following information. Please print clearly.			
Facility Full Name	Facility Term Date	Termed Facility Tax ID Number (TIN)	Facility Office Phone Number
Address		City	State/ZIP Code
Primary Diagnosis (ICD10)		Secondary Diagnoses (ICD10)	Expected Length of Treatment (Up to 90 days from provider termination)
Date of Last Visit (mm/dd/yyyy)		Next Scheduled Appointment (mm/dd/yyyy)	If Maternity: Expected Date of Delivery (mm/dd/yyyy)

Please select 1 of the descriptions if it applies:

☐Life-Threatening Condition ☐Acute Condition ☐Transplant ☐Inpatient/Confined
☐Upcoming Surgery ☐Disabled/Disability ☐Terminal Illness ☐Ongoing Treatment

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Signature of Appointed Facility Representative and Title Date (mm/dd/yyyy)