Continuation of Care Coverage Request
Transition of Care Request

Personal and Confidential

Please complete Sections 1 and 2 of this form completely and accurately to avoid delay in processing this request. The treating physician must complete and sign Section 3 and fax the completed form to the appropriate number below:

HMO/POS – (404)842-8390 or Outside Atlanta (888)246-0226
PPO – (877)254-4971

SECTION 1 **Member/Patient Information**	**Patient Name**	Date of Birth
	Address	Patient's Telephone Number
	Member Id HMO___POS___PPO___	Patient's Fax Number
	Non-network Treating Physician's Name	Physician's Telephone Number
SECTION 2 **Authorization**	I am requesting coverage for continuing care by the provider named above for a condition for which treatment has started. If approved, I understand that the continuing care will be covered for a limited period. Further, I authorize the physician named above to provide medical records to the Plan as required to make a coverage decision.	
	Patient's Signature (Required if Patient is 17 or older)	Date
	Parent's Signature (Required if Patient is 16 or younger)	Date
SECTION 3 **Physician Information**	The above named patient is requesting approval for continuation of care. Although you are terminating as a participating provider in the Plan network, the patient has requested that we cover care provided by you for a specified period of time because of a serious condition or a pregnancy that began before the effective date. In order to evaluate your patient's request, please provide the patient's diagnosis below. Also, please make a brief statement of the patient's current condition and treatment plan together with appropriate medical records. For pregnancy, please enter the patient's estimated date of confinement (EDC). Your signature stands as an agreement that you will continue to provide care for up to 90 calendar days from the date of your contract termination or under the terms of the current contract for this patient. For obstetrical care, this applies through the postpartum period.	
	Diagnosis	Expected Duration of Continuation
	Treatment (If related to Physical or Speech Therapy, also indicate number of visits)	Treatment Date(s)
	Surgery Type (if applicable)	Surgery Date
	Treating Physician's Name (please print)	Telephone Number
	Treating physician's address (please print)	Fax Number
	Treating Physician's Signature	Date