EmblemHealth | UnitedHealthcare

Continuity of Care Form

To complete this form

- Save and download the form to your device.
- Please make sure all fields are completed. Once completed, 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. Use auto-signature to sign it electronically and save the completed form to your device.
- 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.

Submitting your form

Either you or your provider can return the completed form along with relevant medical records and information by mail, fax or submitting online. Whether you or your provider submits the completed form, we encourage you to obtain a copy of the completed form for your records.

By mail: NYCE PPO Continuity of Care, P.O. Box 8042, Wausau, WI 54402-8042
By fax: 855-229-4454
To submit online

1. Sign into **nyceppo.com** or create your account.
2. Select **Contact us** at the top of the screen.
3. In the **Message center** window, fill out required information.
4. In the **Subject** line drop-down, select **Submit Continuity of Care form**.
5. Upload your signed Continuity of Care form.
6. Select **Submit**.

Note: After receiving your request, we will review and evaluate the information provided. Once a 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

Full name of person being treated _____ Date of birth ___/___/___ (MM DD YYYY)

Member ID number (refer to NYCE PPO ID card) _____

Address _____ City _____ State _____ ZIP _____

Phone number ___-___-___

Plan name NYCE PPO Group ID number 76-417151

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)

(Continued)

Care provider Your health care professional should complete the following information.

Provider full name _____ Provider term date ___/___/____ (MM DD YYYY)

Provider tax ID number (TIN) _____ Provider phone number ____-____-____

Address _____ City _____ State _____ ZIP _____

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 copayment, deductible or coinsurance 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 _____ Title _____

Date ___/___/____ (MM DD YYYY)

(Continued)

Care provider Your health care facility should complete the following information.

Facility full name _____ Facility term date ___/___/____ (MM DD YYYY)

Facility tax ID number (TIN) _____ Facility phone number ___-___-____

Address _____ City _____ State _____ ZIP _____

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)

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Signature of appointed facility representative _____ Title _____

Date ___/___/____ (MM DD YYYY)

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