



Continuity of Care Form

UM Department Phone #: 844-824-8653

UM Department Fax #: 888-522-6740

PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.

Requestor's Contact Name:		Requestor's Contact #:	
Patient Information:			
*Name:		*DOB:	
*Medicaid ID		*Patient Phone #:	
Member Information:			
1. Is the member pregnant?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. If yes, when is the due date? (mm/dd/yyyy)			
3. Is the member currently receiving treatment for acute trauma?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is the member scheduled for surgery or hospitalization after the effective date with Prestige?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Is the member involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy, or a candidate for Organ Transplant?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is the member receiving treatment as a result of a recent major surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is the member receiving behavioral health services for a serious mental illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Is the member receiving substance abuse treatment or ongoing treatment for chronic pain?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Is the member receiving care for a terminal illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Please describe above condition. If you did not answer "Yes" to any of the above questions yet request COC, please describe the condition(s) for which there is a request for COC.			
Procedure Information:			
*ICD 10 Diagnosis:		Diagnosis Description:	
*CPT/HCPC Code & Description (Include Unit of Measure / Frequency for supplies):			
*Date(s) of Service:		# of Units or Visits:	
*Place of Service:			
Provider Information:			
Requesting Provider		Is this the patient's Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Name:		*NPI	
*Phone:		*Fax	
*Address:		TIN:	
Rendering Provider		<input type="checkbox"/> Same as the Requesting Provider	
<i>If Requesting and Rendering providers differ, complete section below</i>			
*Name:		*NPI	
*Phone:		*Fax	
*Address:		TIN:	
Facility		<input type="checkbox"/> N/A	
*Name:		*NPI	
*Phone:		*Fax	
*Address:		TIN:	
Request for extension to existing authorization number:			
<p>PLEASE COMPLETE ALL SECTIONS WITH AN ASTERISK AND ATTACH CLINICAL NOTES/SUMMARY TO SUPPORT MEDICAL NECESSITY.</p> <p>INCOMPLETE INFORMATION MAY DELAY THE PROCESS.</p> <p>Always verify eligibility, benefits and prior authorization requirements</p>			
<p><small>Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time of services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.</small></p> <p><small>Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient and use, distribute, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.</small></p>			