Continuity of Care Request Form

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Photocopies are acceptable. Attach additional information if needed.

Please do not include any conditions or treatments for which you are not requesting Continuity of Care authorization.

Contact Information

Name of Person Completing Form			
Contact Phone*		Policy #	
**To complete this process, a valid contact number should be provided by which a BCBSWY representative may reach you*			
Patient's Name		Patient's Birth Date (mm/dd/yyyy)	
Relationship to Policy Holder	☐ Spouse ☐ Dependent ☐ Self		

Maternity

1. Is the patient pregnant? Due Date _____(mm/dd/yyyy) ☐ Yes ☐ No

Serious Conditions

1. Is the patient currently receiving treatment for a condition that is life or limb threatening? ☐ Yes ☐ No
   If yes, please state the serious condition _____
2. Is the patient currently receiving treatment related to an accident? Date of Accident _____(mm/dd/yyyy) ☐ Yes ☐ No
   If yes, please state the serious condition _____
3. Is the patient currently receiving treatment related to a recent trauma? Date of Trauma_____(mm/dd/yyyy) ☐ Yes ☐ No
   If yes, please state the serious condition _____
4. Is the patient scheduled for non-elective surgery? Date of Non-elective surgery_____(mm/dd/yyyy) ☐ Yes ☐ No
   Name of Hospital or Ambulatory Surgery Center, City and State_____

Cancer Related Conditions

1. Is the patient involved in a course of chemotherapy, radiation therapy, or other cancer therapy? ☐ Yes ☐ No
   If yes, please state the primary type of cancer _____
   Date of Diagnosis_____(yyyy)
2. Is the patient currently receiving terminal care? ☐ Yes ☐ No
   If yes, please state terminal diagnosis _____
   If yes, please state terminal care _____
3. Does the patient have a hospice certification? Date of Hospice Certification_____(mm/dd/yyyy) ☐ Yes ☐ No

Dialysis

1. Is the patient receiving dialysis treatment? ☐ Yes ☐ No
   If yes, please state the serious condition _____
   If yes, name of dialysis provider _____
   Frequency of dialysis _____

Transplant

1. Is the patient awaiting a transplant? Date of Transplant_____(mm/dd/yyyy) ☐ Yes ☐ No
   If yes, please state the type of transplant _____
   Date listed with UNOS_____(mm/dd/yyyy)
2. Did the patient recently receive a transplant? ☐ Yes ☐ No
   If yes, please state the type of transplant_____
   Date of next follow up appointment_____(mm/dd/yyyy)

Please continue to complete this form on the next page.

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Medication

1. Are you currently taking any medications that are infused in the home or required to be rendered in a doctor's office, infusion center, clinic, or hospital? ☐ **Yes** ☐ **No**
   If yes, state the name of the drug and the frequency _____

Elective Treatment

1. Is the patient scheduled for elective surgery? Date of elective surgery_____(mm/dd/yyyy) ☐ **Yes** ☐ **No**
   Name of Hospital or Ambulatory Surgery Center, City and State_____

Other Treatment

1. If you are requesting continuity of care and did not answer yes to any item above, please describe the condition for which you are requesting continuity of care below.

Health Care Provider

1. Please complete the health care provider information requested below. This is the provider who has left the network that you are asking for an exception.

Health Care Provider Name			
Health Care Provider Mailing Address			
Health Care Provider City and State			
Health Care Provider Phone		Health Care Provider Fax	
Treatment Expected Duration with Provider			

Authorization

I hereby authorize the above health care provider to give BCBSWY or its affiliates and contracted parties any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care. I understand I am entitled to a copy of this authorization request form.

By: _____ _____

Signature of Patient, Parent or Guardian — Date (mm/dd/yyyy)

Submission

By Mail

Coordination of Care Department Blue Cross Blue Shield of Wyoming

PO Box 2266

Cheyenne, WY 82003-2266

By Fax

307.432.2917