

# Continuity of Care Request Form

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 #	
<i>*To complete this process, a valid contact number should be provided by which a BCBSWY representative may reach you</i>			
Patient's Name			Patient's Birth Date (mm/dd/yyyy)
Relationship to Policy Holder	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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.

# Continuity of Care Request Form

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.

## 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

**By secure upload to the BCBSWY Message Center**  
 See instructions attached

# Form Submission Instructions

Steps for returning a completed form may depend on whether you obtained the form online, received it by email or through another means. Please read the instructions below to decide which submission method suits you best. If the form specifies a preferred method, please follow those directions instead.

**Online:** Download the form and fill it out in the free Adobe Reader ([get.adobe.com/reader](https://get.adobe.com/reader)) or fill out the form online if that option exists and then download it to your device. Save the completed form to your computer or device.

## Submission:

**BY MAIL** – Print and mail the completed form to:

*Blue Cross Blue Shield of Wyoming, PO Box 2266, Cheyenne, WY 82003.*

**BY EMAIL** – Send the form and any required documentation as attachments to a BCBSWY email address, if one is provided.

**BY SECURE UPLOAD** – Follow the directions below to securely upload your form at [Member.YourWyoBlue.com](https://Member.YourWyoBlue.com) ([member.yourwyoblue.com](https://member.yourwyoblue.com)). Click the link or scan the QR code.

After logging in to your [Member.YourWyoBlue.com](https://Member.YourWyoBlue.com) account:

**STEP 1**  
Click on the **Support** button on the menu bar. Scroll down and select **Send a Message**.

**STEP 2**  
Select the plan the form applies to from the list in the panel. Click **Continue**.

**STEP 3**  
Select General–Other as the **Topic**.

**STEP 4**  
Fill in **Callback Preferences** (\*Phone number, \*Best time to call, and \*May we leave a message...?).

**STEP 5**  
Type any message in the **Message** box.

**STEP 6**  
Click on the paperclip icon next to message box to attach a completed form from its location on your device.

**STEP 7**  
Click on the **Send** button to send your message and upload your saved form securely.

