

Continuity of Care from Non-Plan Providers

How to Request Continuity of Care

Keeping your doctor/patient relationship is important. When a Primary Care Physician(PCP) or specialist resigns or is terminated from the medical group, the plan will notify the Member in writing to assist the Member in transitioning care to another medical group physician. If the contract between The Plan a provider group or an acute care hospital terminates, the plan will also notify the affected Members. Members who contact CCHP to request continued Care from a terminated provider will be sent a Continuity of Care request packet by the Member Services Center. The packet includes a Continuity of Care request form. Members must submit a Continuity of Care request form and related documents to the Utilization Review/Care Management Department (attn: UM Director) within 30 calendar days (however, an exception to this 30-day deadline will be made for good cause) of:

- The terminated provider's effective date of termination, or
- The newly enrolled Member's effective date of coverage with the plan.

Utilization review is a process that monitors the use of a comprehensive set of integrated components including: pre-certification review, admission review, continued stay review, retrospective review, discharge planning, and individual medical case management as required to determine medical necessity.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's services.

Eligibility for Continuity of Care Services

The cases that are subject to this Continuity of Care (completion of) services provision are:

- ♦ Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt Medical attention and has a limited duration. We may cover these Services until the acute condition ends.
- ♦ Serious chronic condition, not to exceed 12 months from the date of the provider's termination.
- ♦ Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - it persists without full cure
 - it worsens over an extended period of time
 - it requires ongoing treatment to maintain remission or prevent deterioration
- ♦ Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- ♦ Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- ♦ Care for children, ages 0-36 months, not to exceed 12 months from the date of the provider's termination
- ♦ Authorized surgery or other procedure, if scheduled within 180 days of the date of the provider's termination.

Severe 'mental health' illness of a person of any age and/or the serious emotional disturbances of a Member under 18 years old as defined below in the Mental Health Care section, or Mental Health, Substance Abuse/ Chemical Dependency, Psychological or a Psychiatric, disorder, illness, or condition, which otherwise meet any one of the above criteria.

To qualify for this completion of Services coverage, all of the following requirements must be met:

- ♦ Your Health Plan coverage is in effect on the date you receive the Service
- ♦ For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- ♦ You are receiving Services in one of the cases listed above from a Non-Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date

If the terminated provider does not agree to comply with the plan's contractual terms and conditions that are imposed upon current contract providers, we will not approve the request for continuity of Care services. The Services to be provided to you would be covered Services under the Combined Evidence of Coverage and Disclosure Form if provided by a Plan Provider.

Copayments and Annual Deductibles

For the complete of services and Member's copayments, see CCHP's rates according to the "Description of Benefits and Coverage" section of the Combined Evidence of Coverage and Disclosure Form .

Notice about Certain Reproductive Health Care Providers

Some CCHP contracting hospitals and other providers may not provide one or more of the following services that may be covered under your plan contract and that you or your enrolled family dependents might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; or abortion. You should obtain more information before you enroll. Call your prospective CCHP doctor, or call CCHP's Membership Services Department 415-834-2118 to ensure that you can obtain the health care services that you need.

Contracts with Plan Providers and Compensation

CCHP and Plan providers are independent contractors. CCHP providers are paid in a number of ways, including capitation, per diem rates, case rates, and fee-for-service. If you would like further information about how CCHP providers are paid to provide or arrange medical and hospital care for Members, please call our Member Services Center for a written description of how our providers are paid.

Liability of Member or Enrollee for Payment

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services you obtain from Plan Providers or Non-Plan Providers.

**CONTINUITY OF CARE REQUEST FORM**

Member Name: _____ Date of Birth: _____

Member ID #: _____ Subscriber Name & ID #: _____

Address: _____

Cell Phone: () _____ Home/Work Phone: () _____

Preferred Phone Number to call from 8am to 5pm: Cell Home Work

Primary Care Physician: _____ PCP Phone: () _____

Current Diagnosis (List all that apply): _____

Reason for Requesting Continuity of Care: _____

I am requesting continued care from the following terminated/non-participating provider: _____

Provider Name	Specialty	Address	Phone Number
1.			
2.			
3.			

Member Signature: _____	Date: _____
If completed by someone other than the member: Name of Requestor: _____	Phone Number () _____
Requestor's Signature: _____	Relation to Member: _____

Please Mail To: Continuity of Care Request
 Attn: Director of Utilization Management
 445 Grant Avenue, Suite 700
 San Francisco, CA 94108

OR,

Fax To: (415) 398-3669

For assistance in completing this form, call Member Services at 1-888-775-7888.