P.O. Box 30192, Salt Lake City, Utah 84130
800-538-5038
selecthealth.org

selecthealth

Continuity of Care Request Form

Note: You will need to fill out one form for each provider for each instance in which continuity of care coverage is needed. Transitional coverage decisions are contingent upon SelectHealth's ability to receive and review required information from physician offices, etc. Continuity of care coverage will only be extended for a limited time, and only from the provider, facility, or medical vendor listed on this form, if the required criteria is met. **Please complete this form in its entirety**, as incomplete information may delay the review of this request. Continuity of care coverage decisions will be communicated by letter as soon as reasonably possible.

Name of Requester _____ **Preferred Contact Phone #** (_____)_____

A. MEMBER INFORMATION

Subscriber's First and Last Name _____

Subscriber ID _____ Date of Birth _____
(MM/DD/YY)

Phone # (_____)_____

Patient's First and Last Name _____ Date of Birth _____
(MM/DD/YY)

Provider (first and last name), Facility, or Medical Vendor _____

Phone # (_____)_____

Street Address _____ City _____ State _____ ZIP _____

Required: Brief Description of Type(s) of Care Receiving (include CPT codes and/or diagnosis codes if available)

What was the most recent date of service with this provider, facility, or medical vendor? _____
(MM/DD/YY)

New Insurance Network and Name _____
(N/A for No Insurance/Coverage)

Group ID (optional) _____ Policy ID (optional) _____
(N/A for No Insurance/Coverage) *(N/A for No Insurance/Coverage)*

B. FORM SUBMISSION

There are several ways to submit your continuity of care coverage form:

> Mail

Complete Section A. and return this entire form to the following address:

SelectHealth Member Services
P.O. Box 30192
Salt Lake City, UT 84130-0192

> Fax

SelectHealth Member Services
801-442-6580

C. TO BE COMPLETED BY SELECTHEALTH (MEMBER SERVICES)

Is the member on a Small Employer or Large Employer plan? ❑ **Yes** ❑ **No**

Do the member's services fall within the 90-day timeframe of the letter notification? ❑ **Yes** ❑ **No**

Is the attending provider participating with the member's new plan? ❑ **Yes** ❑ **No**

Was a description of the member's type(s) of care they are receiving listed on this form? ❑ **Yes** ❑ **No**

D. TO BE COMPLETED BY SELECTHEALTH (HEALTHY CONNECTIONS)

Name of Nurse _____ **Extension** _____

1. **Has the member established an active relationship with the provider in question AND does the continuity of care coverage request meet required criteria?** ❑ **Yes** ❑ **No** *If no, the member is not eligible for continuity of care coverage.*

2. **Is the request for continuity of care coverage approved?** ❑ **Yes** ❑ **No**

E. FAIR TREATMENT NOTICE

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電

SelectHealth: **800-538-5038**