Application for Continuity of Care

WHAT IS CONTINUITY OF CARE?

Continuity of Care is a service that enables Blue Cross and Blue Shield of Nebraska (BCBSNE) members to receive time-limited care for specified medical conditions from a non-contracted physician at in-network level of benefits. Continuity of Care eligibility is based upon qualifying events listed in SECTION I of this form.

HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUITY OF CARE BENEFITS?

- Read and complete SECTION I of the Application for Continuity of Care.
- If you answer YES to at least one question, you may be eligible for Continuity of Care benefits.
- If you answered NO to all the questions, you are not eligible for Continuity of Care benefits. You **DO NOT** need to have your physician review or sign the form and you **DO NOT** need to send in the form to BCBSNE.

Should you require assistance locating a new physician in your BCBSNE network, please visit NebraskaBlue.com/DoctorFinder, log into your online account at myNebraskaBlue.com or call the Member Services number shown on your member ID card.

THE APPLICATION PROCESS

1. If you answer YES to at least one of the questions in SECTION I, please complete SECTION II.
2. Ask your physician to complete SECTION III of the application.
   - **If you are receiving care from more than one physician, please submit each request on a separate form. Each physician must individually complete SECTION III.**
3. Mail, fax or email the completed application, along with relevant medical records, to:

Blue Cross and Blue Shield of Nebraska
Continuity of Care - Preauthorization
PO Box 3248
Omaha, NE 68180-0001

Fax: 402-392-4108

Email: Faxline4108-ContinuityofCareFaxes@NebraskaBlue.com

SECTION I - TO BE COMPLETED BY THE PATIENT

1. Are you getting treatment for a serious and complex condition?[1]	☐ Y ☐ N
2. Are you scheduled for non-elective surgery, including post-operative care?	☐ Y ☐ N
3. Are you receiving treatment for terminal illness and undergoing active treatment?	☐ Y ☐ N
4. Are you more than three months pregnant or did you deliver less than six weeks ago?	☐ Y ☐ N
If so has your doctor told you this is a high-risk pregnancy?	☐ Y ☐ N
5. Are you currently undergoing non-surgical treatment (radiation, chemotherapy) for cancer?	☐ Y ☐ N
If yes, please provide last date of treatment: _____	
6. Are you currently undergoing surgical cancer treatment for cancer?	☐ Y ☐ N
If yes, please provide date of surgery: _____	
7. Are you undergoing active treatment for Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)?	☐ Y ☐ N
If yes, please provide last date of treatment: _____	
8. Are you undergoing active treatment for severe or end-stage kidney disease or dialysis?	☐ Y ☐ N
If yes, please provide last date of treatment: _____	
9. Have you undergone a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ?	☐ Y ☐ N
If yes, please provide last date of treatment: _____	
10. Are you currently receiving inpatient services at a facility?	☐ Y ☐ N
If yes, please provide name of facility and date of admission: _____	
11. Are you receiving outpatient or inpatient mental health or substance use disorder services by a licensed mental health provider?	☐ Y ☐ N
If yes, please provide name of your provider and date last seen: _____	
For consideration of mental health and substance use disorder services, contact the telephone number included on your member ID card or at myNebraskaBlue.com.	

[1]The term `serious and complex condition' is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (in the case of an acute illness) or a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time (in the case of a chronic illness).

SECTION II - TO BE COMPLETED BY THE APPLICANT

PATIENT NAME	DATE OF BIRTH (MM/DD/YYYY)	
ADDRESS CITY, STATE, ZIP CODE		
BCBSNE MEMBER ID NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER
PATIENT'S RELATIONSHIP TO MEMBER (I.E., SPOUSE, DEPENDENT, SELF)		

AUTHORIZATION TO RELEASE RECORDS

I authorize all physicians and other health care professionals or institutions to provide Blue Cross and Blue Shield of Nebraska (BCBSNE) information concerning medical care, advice, treatment or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transitional Care benefits under the plan.

PATIENT SIGNATURE OR PARENT/GUARDIAN'S SIGNATURE IF APPLICANT IS A MINOR DATE

PARENT OR GUARDIAN'S PRINTED NAME

SECTION III -TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION FOR THE ABOVE-NAMED APPLICANT.

This section of the form only needs to be reviewed and filled out by your physician IF you answered YES to one or more of the conditions on Section I. If you answered NO to all of the conditions in Section I, your physician does not need to fill out this form.

PHYSICIAN NAME	PHYSICIAN NPI NUMBER	PHONE NUMBER
ADDRESS CITY, STATE, ZIP CODE		
DATE OF LAST VISIT/FREQUENCY OF VISITS		
DIAGNOSIS		
EXPECTED LENGTH OF TREATMENT	IF MATERNITY, EXPECTED DATE OF DELIVERY (MM/DD/YYYY)	
FACILITY NAME	ADDRESS CITY, STATE, ZIP CODE	
CURRENT TREATMENT/COMMENTS		

By signing below, I agree to accept BCBSNE's Contracted Amount, plus the member's deductible, coinsurance and/or copayment, if applicable, for any Covered Services as payment in full. I will not balance bill the member for any amount in excess of BCBSNE's allowable charge for Covered Services. I also agree to all of the terms and conditions applicable to Participating Providers, including the guidelines set forth in the Policies and Procedures Manual.

PHYSICIAN'S SIGNATURE DATE