MEMORIAL HERMANN Health Plan

MEMORIAL HERMANN *ADVANTAGE* HMO

Continuity of Care Form

Continuity of care will be issued under special circumstances to allow members to continue treatment with a non-plan provider(s) for a period of time following the date of enrollment. Please complete this form if you are currently being treated by a non-plan provider. One form must be submitted for each provider.

- Unstable or serious medical problems that require **a limited course of treatment or follow-up care**, such as those listed below may be eligible for continuity of care:
  - Newly diagnosed cancer
  - Recent heart attack
  - Other ongoing acute care

- Members with special needs that require treatments to maintain a level of function will be reviewed on a case by case basis.

- Examples of chronic medical conditions which are **NOT** typically eligible for continuity of care include:
  - Arthritis
  - Diabetes
  - Hypertension (high blood pressure)
  - Asthma and allergies

- If the treating physician is in the Memorial Hermann Advantage network, do **NOT** complete this form. Please refer to the physician listing at URL:healthplan.memorialhermann.org/medicare or call customer service at 855.645.8448 available 8 a.m. to 8 p.m. Monday – Friday, Feb 15 – Sept 30; 8 a.m. to 8 p.m., 7 days a week, Oct 1 – Feb 14 (TTY 711).

- If you have any questions about continuity care or need help completing this form, please call the Memorial Hermann Advantage (MHA) Medical Management Department at: 855.645.8448 (TTY 711).

- Please ask your treating physician to fax any clinical information related to this continuity of care request to the MHA Medical Management Department at 713.338.6982.

CONTINUITY OF CARE INFORMATION

Member Information

Member's Name: _____ DOB: _____

Effective Date of Coverage: _____

Member ID: _____

Preferred Contact Telephone Number: _____

Condition being treated:
_____

How long has the doctor been treating the member for the current condition?
_____ Years _____ Months

How long is the treatment expected to continue?
_____ Years _____ Months

What is the nature of the treatment?
_____

Was the member hospitalized recently for this condition? Yes No
Admission Date: _____

Did the member have surgery? Yes No

What Type? _____

When? _____

Non-Contracted Provider Information

Name: _____

Tax ID or NPI#:_____

Street Address:
_____

City: _____ State: _____

Zip Code: _____

Telephone Number: _____

Specialty: _____

Hospital or facility where surgery or treatment is scheduled or currently being provided:

Telephone number of hospital or facility: _____

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AUTHORIZATION TO RELEASE INFORMATION PERSONAL HEALTH INFORMATION

I authorize

_____

(Provider Name)

to release to MHA Medical Management Department all information relating to past, present, and future health care examinations, conditions, and treatments for:

_____

_____

(Brief Description of Medical Condition)

This information will be used to determine if services for the above provider for the stated condition may be covered on or after the effective date by MHA Medical Management Department. I also understand that MHA does not extend the contractual benefits in any way except to provide coverage for the non-plan provider for a temporary time period.
Member's Signature: _____
Date: _____

Member Representative Signature: _____
Date: _____

FOR OFFICE USE ONLY		
Approved	Denied	Explanations/limitations
Medical Director/Designee:		Date:

TO MEMBER: Please complete this form and return it to the following address:

Memorial Hermann *Advantage*
Medical Management Department
PO BOX 19909
Houston, Texas 77224-1909
Fax to: 713.338.6982