Continuity of Care Assistance Instructional Cover Letter

The Continuity of Care department for Health Net is dedicated to helping assist you in receiving uninterrupted and coordinated care if you are eligible for the Continuity of Care Assistance benefit. To request this benefit, please fill out the Continuity of Care Assistance form located on the second page and return it by either mail or fax.

Please note the following instructions:

1. Please complete the Health Net Continuity of Care Assistance Form to the best of your knowledge. Included:
    - Continuity of Care Assistance Instructional Cover Letter
    - Continuity of Care Assistance Request Form
    - Provider Information Request **(Optional)**

2. The third page (Section 2) is an optional form that may be completed by your provider of services to help assist with your request; however it will not be accepted without the members completed Continuity of Care Form.

3. Please mail or fax all forms to the Health Net Continuity of Care Department at 866-295-4780 or
   Health Net Continuity of Care Unit
   Health Services – 4th floor
   P.O. Box 9103, Van Nuys, CA 91409

Each request is considered for Continuity of Care Assistance based on the plan benefit, applicable state regulations, medical appropriateness and clinical needs. Upon receipt of the Continuity of Care Assistance form, a Nurse Care Manager will be assigned to review your care needs. You will be notified via telephone and/or mail upon receipt of the completed form.

Health Net of California Continuity of Care Assistance Request Form

We understand that you may be obtaining care from a provider who is not or is no longer contracted with Health Net. If you feel you have a special situation such that your care could not be transferred to a Health Net network provider you may request that Health Net review your special situation. Under certain circumstances, you may be entitled to continuation of care with this non-contracted provider.
To request such a review, please provide the information below. You or your authorized representative may complete the form. Please note that filling out the continuity of care form does not guarantee requested services will be covered. Each case is reviewed with guidelines and criteria in place.

Member's Name: _____ Subscriber's Name: _____
Subscriber's ID #:_____ Member's Birth Date: ___ _____
Please Check One: Commercial HMO □ POS/PPO □
Medicare Advantage HMO □ PPO □

Member's Address: _____
Member's Telephone #: Work: (____) _____ Home: (____) _____
Preferred Tel. # to call from 8-5: (____) _____

Current: Medical Group/Insurance Co: _____Phone #: (____) _____
Primary Care Physician: _____ ___Phone #: (____) _____
New: Medical Group/Insurance Co: _____Phone #: (____) _____
Primary Care Physician: _____ _____Phone #: (____) _____
Current Diagnosis / Condition Description: _____

My Medical Need(s) Is/Are (Please Check all that Apply)

□ Acute Condition
□ Serious Chronic Condition
□ Terminal Illness
□ Pregnancy and immediate post partum
□ Scheduled Procedure/Surgery
□ Outpatient Behavioral Services
□ Care of Newborn

Name of Specialist(s): _____Phone # (____) _____
Date of Scheduled Appointment: _____ Authorization # if Avail: _____
Authorized By: _____
Other Special Needs/Comments: ***

_____

_____
Member Signature: _____ Date: _____
If filled out by other than the member:
Name of Requestor: _____ Relation to Member: _____
Phone No. (____)_____ Date: _____

Section 2: This form is optional but if completed must be submitted with the members completed Continuation of care form.

This is not required but will expedite the review of your request.

Section 2- Patient Information (to be completed by the Health Net member)

Subscriber Name: _____Health Net ID (if available):_____

Patient Name: _____DOB:_____ Telephone: _____
Please note that your provider may require you to complete an Authorization for Release of Information.

Provider Information (to be completed by the provider)
Your patient has requested that Health Net cover care provided by you for a specific diagnosis and period of time. If you agree to continue to see your patient and accept Health Net's standard rates, please provide the requested information so that we can evaluate your patient's request. If you are not willing to accept Health Net's standard rates, please indicate so below.

Please check one option below:

☐ Agree to continue to see your patient accepting Health Net's Standard rates.

☐ Not willing to continue to see your patient.

Diagnosis: _____ICD Code(s) _____

Expected Duration of Transition: _____

Treatment/Treatment Plan: _____

Treatment/Surgical Date: _____ For Pregnancies, EDC: _____

CPT Code(s): _____

Treating Provider name (print): _____ Telephone: _____

Tax ID #_____

PLEASE FAX COMPLETED FORM INCLUDING THE FIRST PAGE AND ANY SUPPORTING DOCUMENTATION YOU BELIEVE IS APPRORIATE TO HEALTH NET'S CONTINUITY OF CARE DEPARTMENT AT (866) 295-4780.
Or you can mail it to:
Health Net Continuity of Care Unit
Health Services – 4th floor
P.O. Box 9103, Van Nuys, CA 91409

The Continuity of Care Department may contact you at the number you provided above for additional information or to resolve your patient's request. Thank you for your prompt attention to this matter.