

**Employee Benefit Trust**

1205 Windham Parkway
Romeoville, IL 60446
800.807.0400 / 630.226.2171 fax

Member Request for Continuity of Care

Please complete this form if you are currently receiving medical care from physician(s) that are no longer listed in your provider directory and you would like assistance in continuation of care. Continuity of Care, for covered services, may be available for up to 90 days.

Group Name

Group Number

Employee Name (Last, First, Middle Initial)

ID Number/Social Security Number

Date of Birth

Patient Information

Patient's Name (Last, First, Middle Initial)

Patient's Street Address

Phone Numbers: Home

Date of Birth

Relationship to Employee

City

State

Zip Code

Work

Cell

Medical Information

What is the Health Condition, Diagnosis or Treatment Plan for which the Patient is seeking Transitional Benefits?

Is the Patient receiving care for a Pregnancy? ☐ Yes ☐ No

If Yes, what is the estimated due date?

Is there a Surgery scheduled or recently done? ☐ Yes ☐ No

If Yes, what is/was the date of the surgery?

Is the Patient currently on a Transplant list? ☐ Yes ☐ No

If Yes, please provide a copy of the approval letter.

Does Patient have an appointment scheduled? ☐ Yes ☐ No

If yes, please indicate the date of the Patient's next appointment.

Physician Information

Physician's Name (Last, First, Middle Initial)

Phone Number

Street Address / City / State / Zip Code

Name of Facility (Hospital, DME, Group)

Date of Last Visit

Date of Next Visit

Physician's Name (Last, First, Middle Initial)

Phone Number

Street Address / City / State / Zip Code

Name of Facility (Hospital, DME, Group)

Date of Last Visit

Date of Next Visit

A Utilization Management representative may contact you to obtain medical records for clinical review.

What is the best number to reach you? Home

Work

Signature of Patient or Guardian

Date

Return to:

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