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: _____ ID# / SS#_____Date of Birth: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Relationship to Employee: _____

Address:_____City: _____State:_____ZIP: _____

Phone # Home:_____ 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 Name	Address	Phone #	
	Name of Facility (Hospital, DME, group)	**Date of Last Visit**	**Date of Next Visit**
Physician Name	**Address**		**Phone #**
	Name of Facility (Hospital, DME, group)	**Date of Last Visit**	**Date of Next Visit**
Physician Name	**Address**		**Phone #**
	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: _____

Signed: (Patient or Guardian)_____ Date:_____

RETURN TO:
Christian Brothers Services / HBS
1205 Windham Parkway
Romeoville, IL 60446

HBScustomerService@cbservices.org
630-378-2504 fax