Provider Termination
Continuity of Care Request Form

Anthem

Instructions – Complete this form only if you are receiving ongoing care, or are scheduled to receive care, and your provider is leaving the Anthem network. Please complete a separate form for each family member who may need continuity of care.

Subscriber information

Last name	First name	M.I.	Anthem member ID

Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)

Preferred phone no.	Secondary phone no.
( ) ☐Home ☐Cell ☐Work	( ) ☐Home ☐Cell ☐Work

Diagnosis requiring continuity of care (include pertinent history and physical findings)

Medical information

1. Do you have an upcoming appointment to see a specialist? ☐Yes ☐No If yes, please provide the applicable information below.

Type	Physician name (last, first)/ Physician phone no.	Physician address	Date of next office visit/ Reason
Heart specialist	Name: Phone:		Date: Reason:
Lung specialist	Name: Phone:		Date: Reason:
Blood or cancer specialist	Name: Phone:		Date: Reason:
Neurologist	Name: Phone:		Date: Reason:
Surgeon	Name: Phone:		Date: Reason:
Obstetrician for pregnancy Due date:	Name: Phone:		Date: Reason:
Other – please be specific: _____	Name: Phone:		Date: Reason:

Medical information – Continued

2. Are you currently receiving any of the following services?

Oxygen	☐ Yes ☐ No	Company: _____
IV medication	☐ Yes ☐ No	Company: _____
Home therapy	☐ Yes ☐ No	Company: _____
Inpatient rehab treatment	☐ Yes ☐ No	Company: _____
Medical equipment	☐ Yes ☐ No	Company: _____
Dialysis	☐ Yes ☐ No	Company: _____
Laboratory	☐ Yes ☐ No	Company: _____
Radiation therapy	☐ Yes ☐ No	Company: _____
Other – please be specific: _____	☐ Yes ☐ No	Company: _____

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐ Yes ☐ No

Date: | | | | | | | | Type of surgery/procedure: _____

Name/phone no. of physician performing surgery/procedure: _____

Hospital/facility: _____

4. Other needs/comments: _____

If you answered yes to any of the questions above, you will be contacted to coordinate your continuity of care, if appropriate.

Signature required

I authorize Anthem Blue Cross and Blue Shield to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the Anthem Blue Cross and Blue Shield reviewing unit and/or Care Management any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Continuity of Care. I understand that the Anthem Blue Cross and Blue Shield reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over **X**	Printed name	Date (MMDDYYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MMDDYYYY)