CONTINUITY OF CARE REQUEST FORM

Date: _____

Instructions: 1. Complete Continuation of Care Request form.
2. Send form to the email address, mailing address or fax number listed at the bottom of this form.

Patient Information

_____
Name Date of Birth

Member Information

_____
Name ID Number

_____
Address City, State, Zip Code

Telephone: Home: (__ __ __) __ __ __- __ __ __ __ Work: (__ __ __) __ __ __- __ __ __ __

Doctor Information

_____
Name Specialty

_____
Address City, State, Zip Code

Telephone: (__ __ __) __ __ __- __ __ __ __

Facility Information

_____
Name Specialty

_____
Address City, State, Zip Code

Telephone: (__ __ __) __ __ __- __ __ __ __

Condition Being Treated:

☐ Pregnancy:

Initial Visit Date: _____Due Date: _____

☐ Scheduled Procedures, Surgeries or Tests _____

Date: _____ Location: _____

☐ Post hospital follow-up visits

☐ Other Diagnosis description or Diagnosis code (if available) (Specify) _____

Procedure description or Procedure code (if available) _____

How long is the treatment expected to continue? _____

Additional Comments: _____

_____

MAIL ADDRESS: HealthLink Suite 3700, 233 South Wacker Drive, Chicago, IL 60606 / FAX NUMBER: 800-510-2162 / EMAIL: healthlinkmedmgmtrequests@healthlink.com

PLEASE NOTE: THE SUBMISSION OF THIS FORM DOES NOT GUARANTEE BENEFITS. CONDITION(S) MUST MEET CRITERIA FOR CONTINUATION OF CARE, AND MEMBER'S HEALTH BENEFTT COVERAGE MUST PROVIDE CONTINUATION OF CARE BENEFITS