Providence Health Plan | POWERED BY Collective Health

Continuity of Care and Transition of Care Request Form

When your in-network provider becomes out-of-network, you may request Continuity of Care or Transition of Care coverage if your medical condition prevents an immediate transfer to a network provider.

Continuity of Care (COC) applies when your current in-network provider leaves the medical network and becomes out-of-network.

Transition of Care (TOC) applies when your health plan changes its medical network and your in-network provider is now considered out-of-network with the new medical network.

To qualify, you must meet the criteria below:

- Be undergoing an active course of treatment that is medically necessary and, by agreement between you and your provider, it is desirable to maintain continuity of care.

- A pregnant member qualifies for COC at the start of the second trimester and will receive COC coverage for:
    - 45 days post-birth or
    - As long as the member continues an active course of treatment, but no longer than 120 days from the notice, whichever is later.

You and your provider must complete this form and submit it to Providence Health Plan Powered By Collective Health within 30 days of the provider's network status change. **You must also include the relevant medical records in your request.** If you are requesting continuity of care/transition of care for more than one provider or condition, please complete one form for each provider/condition.

If approved, the covered services rendered by the approved provider will be covered at the in-network benefit level for 120 days from when your provider becomes out-of-network, or the date following when the course of treatment is completed, whichever is earlier.

Please complete all the fields and sign where indicated. Submit the form to Providence Health Plan Powered By Collective Health via

Online: Please visit your Providence Health Plan Powered By Collective Health account and send a secure message or
Fax: 800.351.4301; or
Mail: If you would like to submit this form and medical records by mail, please send it in a security envelope to
ATTN: COC/TOC

Collective Health
1557 W Innovation Way, Suite 300
Lehi, UT 84043

Providence Health Plan | POWERED BY Collective Health

Patient Information	
Patient Name	Patient Date of Birth (mm/dd/yyyy)
Subscriber ID	Subscriber Name
Patient's Relationship to subscriber ◯ Self ◯ Domestic Partner ◯ Spouse ◯ Child	
Is the patient covered by another health plan? ◯ Yes ◯ No If yes, please provide the following information:	
Policyholder Name	Policyholder ID
Policyholder Date of Birth	Group ID
Effective Date of Policy (mm/dd/yyyy)	Termination date of Policy (mm/dd/yyyy)
Name of Policy Carrier	

Authorization to release records:
I authorize the physicians and other healthcare professionals or facilities identified on the form below to provide Providence Health Plan Powered By Collective Health and its business partners information concerning medical care, advice, treatment or supplies for the patient named above. This information will be used to determine the patient's eligibility for Transition of Care/Continuity of Care benefits under the plan.

Patient's Signature, Date (mm/dd/yyyy) (parent or guardian's signature if patient is a minor)

_____ _____

Care Information
This section must be completed by the healthcare professional.

Treating Provider Name	
Phone Number	Fax Number
National Provider Identifier (NPI)	Tax ID Number (TIN)
Address (include city, state, and zip)	
Facility Name	Facility Phone Number
Facility NPI	Facility TIN
Facility Address (include city, state, and zip)	
Date of Last Visit (mm/dd/yyyy)	Next Scheduled Appointment (mm/dd/yyyy)
Diagnosis	Frequency of Visits
Expected Length of Treatment	If Maternity: Expected Delivery Date (mm/dd/yyyy)

Please select **one**(1) applicable reason for requesting continuing care:

- ◯ Life-threatening condition
- ◯ Acute condition
- ◯ Transplant
- ◯ Inpatient/Confined
- ◯ Upcoming surgery
- ◯ Pregnancy
- ◯ Terminal illness
- ◯ Ongoing treatment

Is the treatment for an exacerbation of a previous injury or chronic condition?

- ◯ Yes
- ◯ No

Providence Health Plan | POWERED BY Collective Health

Current Condition and Associated Treatment Plan (include statement and all relevant CPT codes) **Please also attach the patient's medical records.**

We understand you are not, or soon will not be, a participating provider in the patient's health plan's medical network. The patient is receiving treatment for the above medical condition from you and is seeking to continue coverage at the in-network benefit level. If the patient is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the patient's plan, for the applicable time-frame, (2) upon request, share information regarding the patient's treatment, (3) if applicable, make referrals for services, including laboratory services to network providers, or ask for approval before referring a patient to an out-of-network provider, and (4) if applicable, request any required prior authorization before the services are rendered.

Please note the following:
For providers leaving the network: The terms and conditions of your participation agreement with the medical network will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your participation agreement, along with any co-payment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Providence Health Plan Powered by Collective Health, or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

For providers that are out-of-network with the plan's new network: If the patient is eligible, coverage will be provided at the in-network benefit level. Payment will be consistent with the member's benefit plan. You agree to accept this payment along with any co-payment, deductible or coinsurance for which the member is responsible under the plan as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Providence Health Plan Powered By Collective Health , or any payer or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Healthcare Professional, Date (mm/dd/yyyy)