

Continuation of Care Election Form

Arkansas Blue Cross and Blue Shield
P.O. Box 2181
Little Rock, Arkansas 72203-2181
Fax#: 501-378-6647
Attn: Medical Review Division

Note: Continuation of Care Election form will be considered only when **complete** medical information and treatment plan is submitted.

Date Submitted: _____ Member Name: _____

Member ID #: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Medical Condition: This Area To Be Complete By Physician

Diagnosis: _____

Treatment: _____

Medical Necessity for seeking treatment out of Network: _____

Name of physician Completing form: _____

Are you the patient's PCP? Yes No

Physician address and phone number: _____

Is this episode of care: Physician Choice Patient Choice Emergency

In compliance with the Health Care Consumer Act, you may continue to be seen by a provider who does not participate in the True Blue PPO network until your acute condition is resolved or for the first 90 days of 2018, whichever comes first. In order for your claims to be paid the same way they have been in the past, please submit this continuation of care form by no later than **December 15th, 2017**.

By signing below, I'm indicating that I understand the restrictions listed around this continuation of care form.

- Extension of coverage will be for lesser of:
 - The length of the acute condition being treated
 - Or, the first 90 days of 2018 (Extensions beyond 90 days will be granted upon review of medical necessity. Examples of extensions in care include pregnancy and some cancer treatments.)
 - Or, your policy is no longer active with Arkansas Blue Cross and Blue Shield Transition of care to a participating True Blue PPO Network provider
 - Or, transition of care to a participating True Blue PPO Network provider

Signature of Member: _____ Date of Signature: _____

Signature of Provider: _____ Date of Signature: _____

If additional space is needed to complete this form, please use additional paper and attach to this form. Also, attach medical records or documents that support the request.

Return Form with Determination to: Mailing Address or Fax