Continuity of Care Request Form

What is Continuity of Care? Continuity of Care gives existing Hometown Health members the option to request extended care from their current health care professional if he or she has left the health plan network and is now considered out-of-network. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at in-network rates for specific medical conditions for a defined period of time.

You may request to obtain treatment for the specific medical condition from your provider for up to 120 days after the provider left the network if you are actively undergoing a medically necessary course of treatment and the provider agrees that it is best for you to continue your care with them.

How Continuity of Care works: You must already be under active and current treatment by the identified non-contracted health care professional for the specific condition identified on this Continuity of Care Request Form. If your request is approved for the medical condition(s) listed in your form(s), you will receive the in-network level of coverage for treatment of the specific condition(s) by the listed health care professional for a defined time period, as determined by Hometown Health. ***All*** other services or supplies must be provided by an in-network health care professional for you to receive in-network coverage levels. If your plan includes out-of-network coverage and you choose to continue receiving care from the provider listed on this request form beyond the approved defined time period, you must follow your plan's out-of-network requirements, including any prior authorization or notification requirements. The care received after the defined time period will be paid as out-of-network.

The availability of Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits

Can I request Continuity of Care? Yes, if one or more of the below statements apply:

1. You are undergoing treatment from the provider or facility for a serious and complex condition, defined as:

    A. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

    B. In the case of a chronic illness or condition, a condition that is:

        i. Life-threatening, degenerative, potentially disabling, or congenital; and

        ii. Requires specialized medical care over a prolonged period of time.

2. You are undergoing a course of institutional or inpatient care from the provider or facility.

3. You are scheduled to undergo non-elective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery.

4. You are pregnant and undergoing treatment for pregnancy from the provider or facility.

5. You are terminally ill and receiving treatment for such illness from the provider or facility

What can I expect after I complete and submit this form? You will receive a written decision approving or denying your request. We encourage you to find a health care profession or facility participating in the Hometown Health network.

Definitions:

Continuity of Care: Gives Hometown Health members the option to request extended care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Out-of-network: Services provided by a non-participating provider.

Active course of treatment: An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment plan. Discontinuing an active course of treatment could cause a recurrence or worsening of the condition under treatment and interfere with recovery. Generally an active course of treatment is defined as within the last 30 days, but is evaluated on a case-by-case basis.

To complete this form:

- Please make sure all fields are completed. When the form is complete, it must have the member signature of whom Continuity of Care is being requested. If the member is a minor, a guardian signature is required.
- You must complete this form for Continuity of Care within 30 days of the provider's termination.
- A separate Continuity of Care form must be completed for each condition you and/or dependents seeking Continuity of Care.
- Please fax or mail this completed form, along with relevant medical records and information within 30 days following the providers termination to:
  Fax: 775-982-3744 attention Continuity of Care
  or
  Mail: Hometown Health
  10315 Professional Circle
  Reo, NV 89521
  Attn: Continuity of Care

Member Demographics	
Member Name:	Member Phone Number:
Member Address:	Member ID Number:
Member Date of Birth (Month/Day/Year):	Treatment Required and Frequency:
Provider information	
Provider Name:	Date of last visit with Provider:
Provider Specialty:	Provider Address:
Provider Phone Number:	Provider Fax Number

RELEASE OF MEDICAL INFORMATION: By signing this form, I authorize the above health care professional or entity to release my medical records, including any mental health or substance abuse records, to Hometown Health for purposes related to this request. I agree that the information I'm providing is correct.

I understand that I may revoke, in writing, this consent at any time. Otherwise, this consent will expire one year from the date of signature.

_____ _____

Signature of Member/Patient *Date*

To Be Completed by Current Treating Provider		
Member Name:	Member ID Number:	Member Date of Birth:
Provider Name:	Facility Name:	Provider Phone Number:
Provider Specialty:	Provider Tax ID/NPI	Provider Fax Number:
Provider Address:		City, State, & Zip code
Date of Last Visit:	Next Scheduled Appointment:	Diagnosis:
Frequency of Visits:	Expected Length of Treatment:	If maternity, expected dare of delivery?
Please attach the applicable medical records Current Treatment/Comments:		

We understand that soon you will not be a participating provider in our network. Our member is receiving treatment for the above medical condition from you and is seeking continued coverage at the in network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable timeframe, (2) follow our policies and procedures, (3) upon request, share information regarding the member's treatment with us, (4) if applicable, make referrals for services, including laboratory services to in-network providers, or ask for our approval before referring a member to an out-of-network provider, and (5) if applicable, request any required prior approval or authorization before services are rendered. Please note the following:

For providers leaving our network: The terms and conditions of your participation agreement 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 copayment, deductible or coinsurance for which the member is responsible under the plan, is payment in full for the covered service. You agree not to seek to recover nor accept any payment in excess of this amount from the member, Hometown Health, or any payer, person or entity acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

_____ _____

Signature of Provider *Date*

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Print Provider Name