Health Net®

Continuity of Care Assistance Instructions

The Continuity of Care Department for Health Net Health Plan of Oregon, Inc. (Health Net) is dedicated to helping you receive uninterrupted and coordinated care if you are eligible for the Continuity of Care Assistance benefit. To request this benefit, please fill out the Continuity of Care Assistance form located on pages 2 and 3, and return it by fax or mail.

Please note the following instructions:

1. Please complete the Health Net Continuity of Care Assistance Request Form to the best of your knowledge. Included:
   - Continuity of Care Assistance Instructions
   - Continuity of Care Assistance Request Form
   - Provider Information Request **(optional)**
2. Section 2 of the Continuity of Care Assistance Request Form (Page 3) is an optional form that may be completed by your provider of services to assist with your request; however, it will not be accepted without the member's completed Continuity of Care Assistance Request Form.
3. Please fax or mail all forms to the Health Net Continuity of Care Department at 1-866-295-4780 or:

   Health Net Continuity of Care Department
   Health Services – 4th Fl.
   PO Box 9103
   Van Nuys, CA 91409
4. Please contact the Health Net Customer Care Center at 1-888-802-7001 if you need assistance completing this form or if you have any questions regarding this process.

Each request for Continuity of Care Assistance is considered based on the plan benefit, applicable state regulations, medical appropriateness, and clinical needs. Upon receipt of the Continuity of Care Assistance Request Form, a nurse care manager will be assigned to review your care needs. You will be notified by telephone and/or mail upon receipt of the completed form.

Health Net®

Continuity *of* Care

Assistance Request Form

We at Health Net understand that you may be obtaining care from a provider who is not contracted with Health Net. If you feel you have a special situation and your care cannot be transferred to a Health Net network provider on the date of change in your plan, or your new enrollment date with Health Net, you may request that Health Net review your special situation. Under certain circumstances, you may be entitled to continuation of care with this noncontracted provider.

To request such a review, please provide the information below as completely and accurately as possible to avoid delay in processing your request. You or your authorized representative may complete the form. If possible, please complete Section 1 below, then provide this form to your provider to complete Section 2 to assist us in processing your request for continuation of care.

The Continuity of Care Department may contact you at the number provided below for additional information or to resolve your request. Thank you for your prompt attention to this matter. Please note that filling out the Continuity of Care Assistance Request Form does not guarantee requested services will be covered. Each case is reviewed with guidelines and criteria in place.

Section 1 – Continuity of Care Assistance Request Form	
Member's name:	Subscriber's name:
Subscriber's ID #:	Member's date of birth:
Please check one: ☐ HMO ☐ POS ☐ PPO ☐ EPO ☐ HSP	
Member's address:	
Member's telephone # (*work*):	Member's telephone # (*home*):
Preferred # to call from 8:00 a.m. to 5:00 p.m.:	
Current provider information	
Medical group/Insurance company:	Phone #:
Primary care physician:	Phone #:
Current diagnosis/condition description:	
Current treatment(s):	
New provider information (*if you have chosen/been assigned a Health Net network provider*)	
Medical group:	Phone #:
Primary care physician:	Phone #:

Reason(s) for requesting Continuity of Care Assistance	
My medical need(s) include (*Please check all that apply.*)	
☐ Scheduled procedure/surgery ☐ Acute condition ☐ Serious chronic condition ☐ Terminal illness	☐ Pregnancy and immediate postpartum ☐ Care of newborn between birth and age 36 months. Not to exceed 12 months from the effective date of coverage for a newly covered enrollee. ☐ Specialist office visit
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Date of scheduled appointment:	Authorization # if available:
Authorized by:	

Other special needs or comments (*Attach another page for additional information as needed.*)
_____
_____
_____
_____

Authorization of information	
Member signature:	Date:
If filled out by other than the member	
Name of requestor:	Relation to member:
Phone #:	Date:

Section 2 – Provider information request (optional)

This form is optional, but if completed it must be submitted with the member's completed Continuity of Care Assistance Request Form. It is not required but will expedite the review of your request.

Patient information (*To be completed by the Health Net member.*)		
Subscriber name:	Health Net ID (*if available*):	
Address:		
Patient (member) name:	Date of birth:	Phone #:
Non-network treating provider name:		Phone #:
Please note that your provider may require you to complete an Authorization for Release of Information.		

Provider information (*To be completed by the provider.*)	
Your patient has requested that Health Net cover care provided by you for a specific diagnosis and period of time. If you agree to continue to see your patient and accept Health Net's standard rates, please provide the requested information so that we can evaluate your patient's request. If you are not willing to accept Health Net's standard rates, please indicate that below.	
Please check one option: ☐ Agree to continue to see your patient accepting Health Net's standard rates. ☐ Not willing to continue to see your patient. You may skip section below.	
Diagnosis:	ICD code(s):
Expected duration of transition:	
Treatment/Treatment plan:	
Treatment/Surgical date:	For pregnancies, EDC:
CPT code(s):	
Non-network treating provider name (*print*):	Phone #:
Tax ID #:	
Non-network treating provider signature:	Date:

Please fax this completed form and any supporting documentation you believe is appropriate to Health Net's Continuity of Care Department at 1-866-295-4780.

Or you can mail it to:
Health Net Continuity of Care Department
Health Services – 4th Fl.
PO Box 9103
Van Nuys, CA 91409