Request for Continuity of Care

What is continuity of care?

Continuity of Care allows Blue Cross Blue Shield of North Dakota (BCBSND) members to continue receiving covered health care services for specific medical conditions from a non-participating or out-of-network provider. Services are provided for a specific duration of time at the benefit level associated with participating, in-network providers. Continuity of Care eligibility is based upon the events listed in Section 1 of this form.

Please discuss this form with your provider and ask them to complete Section 3. Both you and your provider are required to sign this form before submitting the requested information to BCBSND. BCBSND will review your information and notify you of the decision to approve or deny your Request for Continuity of Care.

How do I know if I am eligible for continuity of care benefits?

1. Read and complete Section 1
2. If you answer **YES** to any question, you may be eligible for Continuity of Care benefits

   If you answer **NO** to all the questions, you are not eligible for Continuity of Care benefits. You do not need to have your provider complete Section 3 or submit this form to BCBSND
3. If you need assistance finding a new participating or in-network provider, please visit www.bcbsnd.com/find-a-doctor or call the Member Services telephone number located on the back of your ID card
4. If you need assistance filling out the form, have questions on the form or want to inquire on your benefit plan, please call the Member Services telephone number located on the back of your ID card.

The Request Process

1. If you answer **YES** to any question in Section 1, please complete Section 2
2. In addition, you need to ask your health care provider to complete Section 3 of this form.
3. Mail or fax the completed form to:
   - Mail:

     Blue Cross Blue Shield of North Dakota
     ATTN: Continuity of Care – Utilization Management
     4510 13th Avenue South
     Fargo, North Dakota 58121-0001
   - Fax: (701) 277-2253

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Reference your benefit plan for applicable benefit.

Section 1 *(To be completed by member)*		
1. Are you at least 3 months pregnant or did you deliver less than 6 weeks ago?	☐ Yes	☐ No
2. Are you pregnant? If yes, has your doctor told you this is a high risk pregnancy?	☐ Yes	☐ No
3. Are you currently getting non-surgical treatment (radiation, chemotherapy) for cancer? If yes, please provide date of last treatment:	☐ Yes	☐ No
4. Are you currently getting surgical cancer treatment? If yes, please provide date of last surgery:	☐ Yes	☐ No
5. Are you getting active treatment for Human Immunodeficiency Virus (HIV) or symptomatic Acquired Immunodeficiency Syndrome (AIDS)? If yes, please provide date of last treatment:	☐ Yes	☐ No
6. Are you getting active treatment for severe or end-stage kidney disease or dialysis? If yes, please provide date of last treatment:	☐ Yes	☐ No
7. Have you received a recent bone marrow or organ transplant, or are you on the waiting list to obtain an organ? If yes, please provide date of last treatment:	☐ Yes	☐ No
8. Are you currently getting inpatient services at a facility? If yes, please provide name of facility and date of admission:	☐ Yes	☐ No
9. Are you currently getting outpatient or inpatient mental health or substance abuse services by a licensed mental health provider? If yes, please provide the name of your provider and date last seen:	☐ Yes	☐ No
10. Are you currently receiving treatment for a serious or terminal condition, non-elective surgery or other life-threatening condition not described above? If yes, please provide the name of your provider, date last seen and detailed description of your condition:	☐ Yes	☐ No

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Section 2 *(To be completed by member)*			
Please complete all the fields below.			
Member Name			Date of Birth *(mm/dd/yyyy)*
Address	City	State	Zip Code
BCBSND Member ID Number	Home Phone Number		Work Phone Number
Member's Relationship To Subscriber *(E.g. Spouse, Dependent, Self)*			

Authorization to Release Records

I authorize all health care providers to provide BCBSND information concerning medical care, advice, treatment, or supplies for the member named above. This information will be used to determine the member's eligibility for Continuity of Care benefits under the plan.

Member Signature	
Member's Signature/Parent or Guardian's Signature if Applicant is a Minor	Date *(mm/dd/yyyy)*

Section 3 (To be completed by health care provider currently treating condition)			
This section of the form only needs to be reviewed and filled out by your provider if you answered **YES** to one of the conditions in Section 1. If you answered **NO** to all of the conditions in Section 1, your provider does not need to fill out this form. Please fill out and ensure the entire form is completed before submitting to BCBSND.			
Provider Name		Provider NPI	
Phone Number		Fax Number	
Address	City	State	Zip Code
Date Of Last Visit	Date Of Next Scheduled Appointment	Frequency Of Visits	
Diagnosis		Expected Length of Treatment	
If Maternity, Expected Date of Delivery	Facility Name		
Current and Planned Treatment/Comments			

Provider Signature	
Provider's Signature	Date *(mm/dd/yyyy)*

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