

## Continuity of Care Request Form

Continuity of care requests applies to large group, small group and individual plan enrollees. If you are currently receiving treatment, a new member or an existing member whose physician is leaving or left the Sutter Health Plus (SHP) network, you may request to temporarily remain with your current treating physician. Please see the *What is Continuity of Care* section of this form for more information about continuity of care and whether you may be eligible. To request continuity of care, complete this form for each physician you want to retain. You must complete all sections. An incomplete form may delay your continuity of care request. Return completed form to Sutter Health Plus within 30 days before or 60 days after your Sutter Health Plus effective enrollment date (if new) or within 30 days of the date your physician left the network. Sutter Health Plus will notify you if you qualify for continuity of care. If you have questions regarding this form or continuity of care please call Sutter Health Plus Member Services at 1-855-315-5800.

**IMPORTANT NOTE:** Continuity of care does not apply to a new member who had the option to continue coverage with his or her previous health plan or provider (including through an out-of-network option) and who instead voluntarily changed health plans.

Section 1: Patient Information			
Last Name:		First Name:	
		MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Diagnosis:			DOB:
Street Address:			Relationship to Subscriber:
City:			State: ZIP:
Home Phone:	Cell Phone:	Work Phone:	
Section 2: Subscriber Information			
SHP Subscriber ID # (If already enrolled):		SHP Effective Date:	
Last Name:		First Name:	
		MI:	
Street Address:			
City:		State:	ZIP:
Home Phone:	Cell Phone:	Work Phone:	
Employer:			
Is SHP the only insurance carrier offered from this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of last Health Insurance Carrier Prior to Joining SHP:			
Type of Benefit Plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other			
Does this employer still offer this Insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain:			

**Section 3: Current Provider/Specialist Information**

(\*If continuity of care is needed for more than one specialist please check here \_\_\_\_\_ and list additional specialists/providers with address and treatment information on the back of this form.)

SHP Primary Care Physician (PCP):

Non-SHP Specialist Providing Treatment:

Type of Specialty:

Specialist's Phone Number:

Specialist Street Address:

City:

State:

ZIP:

**Section 4: Diagnosis Questionnaire**

1.	Is this patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No* <b><i>*If No, skip to question #2 below.</i></b> a) Expected due date: _____ b) Name of OB/GYN provider: _____ c) Name of hospital in which patient wishes to deliver: _____
2.	Diagnosis:
3.	Is the patient currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Date treatment started:
5.	Date of next scheduled treatment/appointment:
6.	Current treatment/need (briefly describe):

I authorize the medical providers listed above to disclose all medical records to Sutter Health Plus for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after Sutter Health Plus completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and Sutter Health Plus are required under state and federal law to keep my medical information confidential. I understand that Sutter Health Plus will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

\_\_\_\_\_  
Signature Patient or Parent/Guardian (if patient is a minor child)

\_\_\_\_\_  
Date

**Please return this completed form to:**

**Sutter Health Plus**  
**P.O. Box 160305**  
**Sacramento, CA 95816**  
**Fax: 916-736-5421 or Toll-Free Fax: 1-855-759-8752**  
**[sutterhealthplus.org](http://sutterhealthplus.org)**

## **WHAT IS CONTINUITY OF CARE?**

In certain circumstances (described below), you may temporarily continue care with a physician who is not part of Sutter Health Plus' network (a "non-participating provider"). You may continue care with a provider if you are being treated by a provider who has been terminated from Sutter Health Plus' network, or you are a new member who has been receiving care from a non-participating provider if you meet the continuity of care requirements explained below.

## **CONTINUITY OF CARE REQUIREMENTS**

In order for you to be eligible for continued care, the non-participating provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by a Sutter Health Plus medical director on a case-by-case basis.

- An acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition
- A serious chronic condition: a serious chronic condition is a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Sutter Health Plus in consultation with the member and the terminated provider or non-participating provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly enrolled member
- A pregnancy. Care will be continued for the duration of the pregnancy and the immediate postpartum period
- A terminal illness. An incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness
- Care of a newborn child whose age is between birth and 36 months. Care shall be continued for up to 12 months from contract termination of provider or from effective date of coverage for a newly covered member
- Performance of surgery or other procedure that has been authorized by Sutter Health Plus (or its contracted medical group) as part of a documented course of treatment that is to occur within 180 days of the provider's termination date or the effective date of coverage for a new member

## **IMPORTANT EXCEPTIONS**

Provider Requirements: Non-participating providers are required to agree to Sutter Health Plus' credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If non-participating providers do not agree to these contractual terms and conditions, you are not eligible to continue care with that provider. Participating providers who are terminating are compensated pursuant to the terms of the terminated provider agreement for the statutorily required period of time when such arrangements are specified in the particular Participating Provider Contract.

A non-participating provider and a provider whose terminated contract does not specify that compensation for continuity of care services will be compensated under the terms of the terminated contract, will be compensated at the same rate that is paid to similar participating providers that are non-capitated providers for similar services in the same geographic region, unless otherwise agreed by the Plan and the non-participating provider.

Neither Sutter Health Plus nor the participating medical group is required to continue the provider's services if the non-participating provider or terminated provider does not agree to comply or does not comply with the contractual terms and conditions as to similarly situated providers as described above.

Member/Subscriber Voluntary Change in Coverage: Continuity of care does not apply to a new member who had the option to continue with his or her previous health plan or provider (including through an out-of-network option), and instead voluntarily changed health plans.

**IMPORTANT:** Language assistance services, including translations of vital documents and interpreter services are available for our members who have a limited or no ability to speak English. These language assistance services are available to you at no cost. To get an interpreter or to ask about written information in your language, please contact Member Services at 1-855-315-5800 (TTY users call 1-855-830-3500).

**IMPORTANTE:** Los servicios de asistencia en idiomas, incluyendo traducciones de documentos importantes y servicios de interpretación, están disponibles para nuestros miembros que tienen una limitación o no son capaces de hablar inglés. Estos servicios de asistencia de idiomas están disponibles para usted sin ningún costo. Para obtener a un intérprete o para solicitar información por escrito en su idioma, por favor comuníquese con servicios al miembro al 1-855-315-5800 (usuarios de TTY deben llamar al 1-855-830-3500).