Application for Continuity of Care Accommodation

MEDCOST® BENEFIT SERVICES
d/b/a MBS Third Party Administrators in California

INSTRUCTIONS

Continuity of Care accommodations entitle members to receive services at in-network coverage levels for certain medical and behavioral conditions for a limited time period when their health care providers leave a plan's network and the immediate transfer of care to another health care provider would be inappropriate and/or unsafe.

Continuity of care accommodations are available in cases where a health plan provider leaves the plan's network and a current patient of that provider:

(i) is undergoing a treatment for a serious and complex condition;
(ii) is undergoing a course of institutional or inpatient care;
(iii) is scheduled to undergo nonelective surgery, including postoperative care;
(iv) is pregnant and undergoing a course of treatment for the pregnancy; or
(v) is or was determined to be terminally ill and is receiving treatment for such illness.

A "**serious and complex condition**" is defined, in the case of an acute illness, as a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Requests for a Continuity of Care accommodation will be reviewed by a medical professional and will be based on the information provided on this form about specific medical conditions. You have 30 days to request Continuity of care accommodation from the date you are notified of your provider's termination from the MedCost Network.

You will be notified after a decision is made about whether your accommodation has been approved. If your request is approved, you may continue to see your current provider through the time frame specified in your authorization.

If you are eligible for a Continuity of care accommodation according to the list above, please complete the applicable questions and:

- Fax this completed form to MedCost Benefit Services at 336-970-2098, Attn: Care Management Appeals & Review Coordinator
- Or, mail to MedCost Benefit Services, Attn: Care Management Appeals & Review Coordinator, P.O. Box 25987, Winston-Salem, NC 27114-5987

Patient Name			Date	
Date of Birth	MedCost Member Number	Employer/Group Name		
Address	City	State	ZIP	
Home Phone	Work Phone			
Provider's Name			Provider's Phone	
Provider's Address	City	State	ZIP	

If you received a notification of provider termination from MedCost:	
What is the provider termination date?	What is the date of the letter?

ONLY complete the sections below that apply to you or your dependent.

What qualifying condition is being treated by the terminated provider?

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Treatment for a Serious and Complex Condition	
What is the condition?	
What services are you receiving?	
Where are you receiving services?	
Date of Scheduled Appointments	Date of Last Service
Name of Provider Rendering Services	

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Currently Undergoing a Course of Institutional or Inpatient Care	
Diagnosis and Treatment	Admit Date
Facility Name	
Facility Address	

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Scheduled for Nonelective Surgery and Postoperative Care	
Diagnosis and Procedure	
Inpatient or Outpatient	Admit or Surgery Date
Facility Name	
Facility Address	

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Pregnant and Undergoing Treatment for Pregnancy	
Delivery Date or Due Date	Next Appointment Date
Facility Name	

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Terminally Ill and Receiving Treatment for Illness	
What is the condition?	
What services are you receiving?	
Where are you receiving services?	
Date of Scheduled Appointments	Date of Last Service
Name of Provider Rendering Services	