BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
www.bcbsvt.com

Continuity of Care Request Form

Patient Name:		Date of Birth ______/_______/_______
Patient Address:		Preferred Phone Number (____) ______ - _________
Preferred Email Address:		Best time of day to call ☐ Morning ☐ Afternoon
Member ID Number	Employer Name	Coverage Effective Date ______/_______/_______

Check off the reason for filling out this form and provide all requested details within the applicable section.

☐ You are a new member to BCBSVT and have a chronic medical, mental health, or substance dependence condition for which you have been actively seeking care with a provider who is not in your network

Name of Condition:	Is condition life threatening, disabling, or degenerative? ☐ Yes ☐ No
Provider's Name:	Provider's Phone Number (____) ______ - _________

☐ You are a new member to BCBSVT and are in the second or third trimester of your pregnancy

Expected Due Date ______/_______/_______	Trimester ☐ Second ☐ Third
Provider's Name:	Provider's Phone Number (____) ______ - _________

☐ You are a new member to BCBSVT and have previously received approval from a prior insurance carrier for an upcoming scheduled service

Description of Service	Date of Scheduled Service ______/_______/_______
Reason for Scheduled Service:	
Provider's Name:	Provider's Phone Number (____) ______ - _________

☐ You are a new member to BCBSVT and are currently taking a medication for which BCBSVT requires prior approval or a step therapy program (visit http://www.bcbsvt.com/pharmacy/rx-program for details)

Name of Medication:	Name of Medication:
Current Dose:	Current Dose :

☐ You are an existing member of BCBSVT, but we sent you notification that a provider you're seeing is no longer in your network

Reason for Seeing Provider	
Provider's Name:	Provider's Phone Number (____) ______ - _________

For all other circumstances, please speak to your provider or contact our customer service team at the number listed on the back of your ID card to learn how to submit a request for prior approval.
I hereby authorize Blue Cross and Blue Shield of Vermont (BCBSVT), its subsidiaries, employees, officers, and agents to use the information set out above or in any attachments hereto to contact my provider(s) on my behalf in order to obtain the necessary information to manage and determine my health benefits and to discuss clinical information related to the coordination of my health care.

I authorize my health care provider(s) to provide BCBSVT with all the information and records, which could be given to me upon request. This may include medical or mental health information, and information related to treatment for alcohol or drug abuse and/or sexually transmitted disease(s).

The purpose of providing this information to BCBSVT is to coordinate my health care and determine health care benefits.

I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. However, BCBSVT and my provider(s) are obligated to protect my protected health information consist with state and federal laws.

Unless revoked, this authorizations is valid from the date of my signature until the date I am no longer insured by BCBSVT or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.

This authorization shall terminate on (specify date, if applicable) ___________________________.

I understand that I may revoke this authorization at any time by mailing *written* notice of my revocation to BCBSVT, ATTN: Privacy Officer, PO Box 186, Montpelier, VT 05601. I understand that revocation of this authorization will not affect any action BCBSVT, its subsidiaries, affiliates, employees, officers and agents including, but not limited to, Express Scripts Inc. and Vermont Collaborative Care, LLC took in reliance on this authorization before it received my written notice of revocation.

Signature of Patient:____ Date: ______/_______/_______
(if patient is age 12 or older)

Signature of Parent/Guardian:____ Date: ______/_______/_______
(if patient is under age 12)

Please return this completed Continuity of Care Request form to:

Mail — BCBSVT Integrated Health
P.O. Box 186
Montpelier, VT 05601

Fax — (866) 387-7914

Upon receipt of this form, and once membership is active, you may receive notification in writing relating to your request. If upon review of your form, it is determined that you may benefit from one of our chronic care, maternity wellness, or case management programs, we may contact you by phone.