CONTINUITY OF CARE REQUEST FORM

Please complete this form if you are currently receiving medical care from a physician / facility that is no longer participating in your provider network and you would like assistance in continuation of care. Continuity of Care, for covered services, may be available for up to 90 days.

Member Name: ____________________________________ **ID # / SSN:** ________________________________

Patient Name: _____________________________________ **Patient Date of Birth:** _______________________

Relationship to Member: ____________________________

Patient Address (Street, City, ST, Zip): ____

Patient Phone: (home) ____________________________ **(cell)** ____

MEDICAL INFORMATION

What is the Health Condition, Diagnosis, or Treatment Plan for which the Patient is seeking Continuity of Care Benefits?

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Is Patient Receiving Care For Pregnancy? **YES** ☐ **NO** ☐ If Yes, due date? ________________

Is There a Surgery Scheduled or Recently Done? **YES** ☐ **NO** ☐ If Yes, date of surgery? ____________

Is The Patient on a Transplant List? **YES** ☐ **NO** ☐

Is The Patient Receiving Cancer Treatment? **YES** ☐ **NO** ☐

Is There an Upcoming Appointment? **YES** ☐ **NO** ☐ If Yes, please indicate date of next appointment? _______________

PROVIDER INFORMATION:

Physician / Facility Name: ____

Physician / Facility Address (Street, City, ST, Zip): ____

Physician / Facility Phone Number: ________________________________ **Date of Last Visit:** __________________

Your case will be reviewed by a Utilization Management Nurse who also may contact you or your provider to obtain medical records for clinical review.

Signed: (Patient or Guardian) ______________________________________ **Date:** ____________________

Mail Completed Form To:
LINECO, 821 Parkview Blvd, Lombard, IL 60148
Attn: Clinical Review Team

OR

FAX To: 630 - 916 -7698,
Attn: Clinical Review Team