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.

I am a new member to BCBSVT

○ I have a chronic medical, mental health, or substance use disorder for which I have been actively seeking care with a provider who is not in my network

Name of Condition:	Is condition life threatening, disabling, or degenerative? □ Yes □ No
Provider/Facility Name:	Provider/Facility Phone Number (____) _____ - _____

○ I am receiving pregnancy care.

Expected Due Date _____/_____/_____	
Provider/Facility Name:	Provider/Facility Phone Number (____) _____ - _____

○ I 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/Facility Name:	Provider/Facility Phone Number (____) _____ - _____

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I am an existing member of BCBSVT

○ BCBSVT sent me notification that a provider I'm seeing is no longer in my network

Name of Condition:	Is condition life threatening, disabling, or degenerative? □ Yes □ No
Provider/Facility Name:	Provider/Facility Phone Number (____) _____ - _____

○ I am receiving pregnancy care

Expected Due Date _____/_____/_____	
Provider/Facility Name:	Provider/Facility 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 consistent 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)

Mail BCBSVT Utilization Management
P.O. Box 186

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Please return this completed Continuity of Care Request form to:

Montpelier, VT 05601
Fax (866) 387-7914

Upon receipt of this form, and once membership is active (if you are not currently a member), you will 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.

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