Continuity of Care Request Form

INSTRUCTIONS

If your health care provider or facility is leaving the network of your health plan, you may ask your health plan for continued coverage of treatment by that provider or facility at the in-network benefit level for a limited period of time. This is called "continuity of care." State and federal laws require your health plan and the provider to agree to this arrangement for certain types of providers and health care conditions.

You must submit this form to request continuity of care. You and your health care provider must provide all the information requested below to allow your health plan to determine if you qualify for continuity of care under state or federal law. Please submit your completed form to *Renaissance Life and Health Insurance Company at claims@renaissancefamily.com.*

MEMBER AND PATIENT INFORMATION

Member's Name		Member's Date of Birth (mm/dd/yyyy)	
Patient's Name (if different)		Patient's Date of Birth (mm/dd/yyyy)	Patient Relationship to Member: ☐ Spouse ☐ Dependent ☐ Self
Street Address		Member ID #	
City		Group Name (If Applicable)	
State	Zip Code	Group # (If Applicable)	
Primary Telephone Number		Secondary Telephone Number (Optional)	

HEALTH CARE PRACTITIONER/FACILITY INFORMATION – to be completed by the provider

If continuity of care is being requested for a behavioral health care provider who has submitted a claim to the health plan on the patient's behalf within the past 3 months or for the patient's primary care provider (including a primary dental care provider), Maryland law requires the health plan to approve the patient's request for continuity of care for all covered health care services received from that provider, regardless of which health condition(s) the provider is treating the patient for. For all other providers, the health plan must collect certain information about the patient's health care condition to determine if the patient is eligible for continuity of care.

For requests that are not for a primary care provider or a behavioral health care provider, a separate form is required for each health care condition for which continuity of care is being requested. If the patient is currently being treated by multiple practitioners for the same heath care condition, please use the additional pages at the end of the form to include identifying information for each practitioner. However, if requesting continuity of care for the same health care condition for services provided by multiple practitioners at the same facility, please provide only the facility information in the provider sections of this form. Note that in order to process the continuity of care request in this situation, the health plan may need to request additional information from the facility about specific health care practitioners who will be involved in the care plan.

Name of Health Care Practitioner/Facility		National Provider Identifier (NPI) or Tax ID Number (TIN)	
Street Address		City	
Telephone Number	Fax Number	State	Zip Code

Is the provider the patient's primary care provider (including a primary dental care provider) or a provider who rendered behavioral health care services to the patient in the last 3 months? ☐ Yes ☐ No

If yes, the DIAGNOSIS REQUIRING CONTINUITY OF CARE section may be left blank.

DIAGNOSIS REQUIRING CONTINUITY OF CARE – to be completed by the provider (attach additional pages if necessary)

Diagnosis Code(s) (ICD-10)	Date Treatment Started (mm/dd/yyyy)	Date of Next Treatment/Visit (mm/dd/yyyy)
Expected Treatment (including related procedure codes)		Expected Length of Treatment
		If Maternity, Expected Date of Delivery (mm/dd/yyyy)
		If Maternity, Expected Place of Delivery

Include a brief statement of the patient's current condition and treatment plan

SIGNATURES/AUTHORIZATIONS	
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.	
Signature of Health Care Practitioner or Facility Representative	Date (mm/dd/yyyy)
I hereby authorize the above health care provider to give Renaissance Life and Health Insurance Company any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for continuity of care. I understand I am entitled to a copy of this authorization request form.	
Patient's Signature (or Parent/Guardian's Signature if Patient is a Minor)	Date: (mm/dd/yyyy)
Printed Name of Parent/Guardian if Patient is a Minor	Relationship to Patient
To check the status of your continuity of care request after submission, please email Renaissance Life and Health Insurance Company at claims@renaissancefamily.com.	

ADDITIONAL HEALTH CARE PRACTITIONERS/FACILITIES INVOLVED IN TREATMENT PLAN FROM PAGE 1
(attach additional pages if necessary)

1. Name of Health Care Practitioner/Facility		National Provider Identifier (NPI) or Tax ID Number (TIN)	
Street Address		City	
Telephone Number	Fax Number	State	Zip Code
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.			
Signature of Health Care Practitioner or Facility Representative			Date (mm/dd/yyyy)

2. Name of Health Care Practitioner/Facility		National Provider Identifier (NPI) or Tax ID Number (TIN)	
Street Address		City	
Telephone Number	Fax Number	State	Zip Code
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.			
Signature of Health Care Practitioner or Facility Representative			Date (mm/dd/yyyy)

3. Name of Health Care Practitioner/Facility			National Provider Identifier (NPI) or Tax ID Number (TIN)
Street Address			City
Telephone Number	Fax Number	State	Zip Code
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.			
Signature of Health Care Practitioner or Facility Representative			Date (mm/dd/yyyy)

4. Name of Health Care Practitioner/Facility			National Provider Identifier (NPI) or Tax ID Number (TIN)
Street Address			City
Telephone Number	Fax Number	State	Zip Code
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.			
Signature of Health Care Practitioner or Facility Representative			Date (mm/dd/yyyy)

5. Name of Health Care Practitioner/Facility			National Provider Identifier (NPI) or Tax ID Number (TIN)
Street Address			City
Telephone Number	Fax Number	State	Zip Code
If this request for continuity of care is approved, the health care provider or facility agrees to accept as payment in full for the authorized course of treatment payment from Renaissance Life and Health Insurance Company and cost-sharing from the patient, as applicable.			
Signature of Health Care Practitioner or Facility Representative			Date (mm/dd/yyyy)