Clear Form

Request for Continued Transitional Care

The Consolidated Appropriations Act of 2021 allows certain patients the opportunity to continue care with respect to terminations of certain contractual relationships resulting in changes in provider network status. Continuing care patients have the opportunity to elect to continue to have benefits provided under the plan, under the same terms and conditions as would have applied and with respect to the items and services as would have been covered under the plan had the change not occurred beginning on the date on which this notice is provided and ending on the earlier of 90 days from the date of the notice or the date on which such individual is no longer a continuing care patient. Please complete this fillable form on pages 2 and 3 for consideration according to the instruction if you believe you may qualify and wish to elect to receive benefits as described above. An authorization is also included on page 4 for your review and completion. Forms can be submitted under the methods outlined on page 4. You will timely either receive a request for additional information or a determination of whether your request has been approved.

Eligibility Criteria

Initial criteria must be met:

- The contractual relationship between the plan and provider/facility is terminated;
- Benefits provided under the plan with respect to the provider/facility are terminated because of a change in the terms of the participation of such provider/facility in the plan; or
- A contract between the plan and health insurance issuer offering coverage in connection with the plan is terminated, resulting in a loss of benefits provided under the plan with respect to the provider/facility.

In other words, was there a change in provider/facility network status resulting in the provider you were seeing now being considered out of network?

Secondary criteria must also be met:
You must also be considered a "continuing care patient." Are you experiencing any of the below?

- Undergoing a course of treatment for a serious and complex condition;
- Undergoing a course of institutional or inpatient care;
- Scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care;
- Pregnant and undergoing a course of treatment from the pregnancy; or
- Determined to be seriously ill. (as determined under section 1861(dd)(3)(A) of the Social Security Act).

"Serious and complex condition" means in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. 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.

Attention: The following information must be included to review this request. For the request to be considered complete and eligible for review, it must meet the eligibility criteria and include a completed form and all relevant documentation.

Additional Documents Required if Applicable:

a) Initial Consult Report from the treating provider(s);
b) Designating which secondary criteria you believe you qualify under and a short summary as to why;
c) Current treatment plan;
d) Last three progress notes;
e) Any and all ICD-10 and CPT codes.

Fillable Form (below)

Subscriber/Patient information	
Covered Person's name:	Covered Person's ID number:
Patient Name if different:	Patient DOB:
Address:	City, State Zip:
Home phone number:	Cell phone number:
Name of previous health insurance company and/or plan:	Date in network coverage ended:

Provider information 1		
Requesting provider first and last name:		NPI:
Provider address:		
City:	State:	ZIP code:
Provider specialty:		
Provider phone number:	Provider fax number:	
Condition/diagnosis being treated, including ICD-10 and/or CPT codes:		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Provider information 2		
Requesting provider first and last name:		NPI:
Provider address:		
City:	State:	ZIP code:
Provider specialty:		
Provider phone number:	Provider fax number:	
Condition/diagnosis being treated, including ICD-10 and/or CPT codes:		
Original start date with provider:		
Date of last office visit/treatment:		
Date of next appointment/treatment:		

Medical information	
If pregnant, what is the expected delivery date?	
Name of delivering hospital:	Name of OB/GYN:
Is member currently hospitalized? ☐ Yes or ☐ No	Name of hospital:
Is member currently receiving home health care or hospice? ☐ Yes or ☐ No	
Name of home healthcare provider or hospice:	
Healthcare provider or hospice Tax ID:	
Phone number:	
Does the member have a terminal condition? ☐ Yes or ☐ No	ICD-10:
Additional information to be considered	
Please list any additional information to be considered:	

Eligibility

Are you experiencing any of the below?

- Undergoing a course of treatment for a serious and complex condition? Yes__ or No__
- Undergoing a course of institutional or inpatient care? Yes__ or No__
- Scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care? Yes__ or No__
- Pregnant and undergoing a course of treatment from the pregnancy? Yes__ or No__
- Determined to be seriously ill? Yes__ or No__

Member Certification, Authorization, and Signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize the above health care provider to give Auxiant any and all information and medical records 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.

Signature of Patient, Parent or Guardian: _____ Date of signature: _____

Phone number where we may reach you: _____

Submission of Form and Document

Possible options include:

- Fax to 319-866-9889
- Mail to PO Box 75008, Cedar Rapids, IA 52407