

Continuation of Care Form

For use with Local NASCO Accounts Only

Date: _____

- Instructions:**
1. Complete Continuation of Care Request form.
 2. Mail form to the address at the bottom of this form.

Patient Information

Name _____ Date of Birth _____

Member Information

Name _____ ID Number _____

Address _____ City, State, Zip Code _____

Telephone: Home: (____) ____-____-____ Work: (____) ____-____-____

Doctor Information

Name _____ Specialty _____

Address _____ City, State, Zip Code _____

Telephone: (____) ____-____-____

Condition Being Treated:

Pregnancy:
Initial Visit Date: _____ Due Date: _____

Scheduled Procedures, Surgeries or Tests _____
Date: _____ Location: _____

Post hospital follow-up visits

Other (Specify) _____

How long is the treatment expected to continue? _____

Additional Comments: _____

PLEASE NOTE: THE SUBMISSION OF THIS FORM DOES NOT GUARANTEE BENEFITS. CONDITION(S) MUST MEET CRITERIA FOR CONTINUATION OF CARE, AND MEMBER'S HEALTH BENEFIT COVERAGE MUST PROVIDE CONTINUATION OF CARE BENEFITS.

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| <p>Medical Management</p> | <p>Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: IN0205-A546 220 Virginia Ave Indianapolis, IN 46204 Fax#: 866-959-2154</p> | <p>Transplant</p> | <p>Transplant Department Anthem BC/BS 4361 Irwin Simpson Road Mail Point: OH0102 Mason, OH 45040 Fax#: 866-255-2471</p> |
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