Motion Picture Industry Health Plans
Continuity of Care Guidelines

Continuity of Care (COC) provides for the completion of covered services that began prior to the provider termination date. A request for COC must meet the criteria outlined below:

1. A surgery or other treatment which has been recommended and documented by the provider prior to the provider termination date and scheduled to take place within 90 days of the provider termination date and continued care is authorized by Blue Shield of California.

2. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention that has a limited duration. Covered services shall be for the duration of the acute condition or until the patient can be safely transferred to a Blue Shield contracting provider, whichever is earlier.

3. A serious chronic condition, for the period of time necessary to complete a course of treatment and to arrange for safe transfer of care to a Blue Shield contracting provider as determined by Blue Shield in consultation with the terminated or non-participating provider, and consistent with good professional practice. Examples may include chemotherapy or radiation therapy.

4. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period including well-baby care for newborns after birth while at the facility at which the baby is delivered. Completion of covered services shall be provided for the duration of the pregnancy.

5. Terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be for the duration of the terminal illness (example: hospice services).

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Request for Continuity of Care

FOR BLUE SHIELD INTERNAL USE ONLY:

Line of Business: MPIPHP

Customer Services Advisor Name: ______________________

Customer Services Advisor Phone: ______________________

Health Plan Effective Date: ______________________

Fax to Blue Shield: 530-531-6200 Attn: MPI Continuity of Care

Participants should keep a copy for their records and send the completed form as soon as possible to:

By Mail:
Blue Shield of California – Shared Advantage
Attn: MPI - Continuity of Care
4700 Bechelli Lane
Redding, CA 96002-3506

By Fax: 530-531-6200 Attn: MPI Continuity of Care

Or call Blue Shield Customer Service at 800-219-0030 (opt. 1, then 1 again to speak with a representative) if you have any questions or concerns regarding this request form.

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1. Member Identification

Member Name: ______________________ Member SSN ______________________

Date of Birth: ______/_______/_________

Street Address: ______________________ City______________________

State, Zip Code: ______________________ Home Phone: ( ) ______________________

2. Patient's Continuity of Care Information (1 patient per form!)

Patient Name: ______________________ Date of Birth: ______/________/__________

Relationship to Member: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child

Home Phone: ( ) ______________________

3. Patient's Medical Information

Complete Section 3 of this form for EACH treating physician for which Continuity of Care is requested.

Current Treating Physician requesting Continuity of Care:

Name: ______________________ Phone: ( ) ______________________

Address: ______________________

Treating Physician Specialty: ______________________

__NOTE:__ Blue Shield of California may be requesting medical information from your provider in order to evaluate your continuing care request. The determination for your Continuity of Care request will be made once the information has been received and reviewed.

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3. Patient's Medical Information-- *continued*

Condition or Diagnosis being treated:

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When did care start with treating physician? (Date) ______________________

If maternity, expected date of delivery and at which hospital: Date: ______________________

Hospital: ______________________

Are there any outstanding surgeries planned at this time? ☐ Yes ☐ No
If **yes**, please list type(s) of surgery planned and dates:

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Is patient hospitalized now? ☐ Yes ☐ No
If **yes**, please list Provider's Name: ______________________

Address ______________________ Phone: ( ) ______________________

4. Additional medical information regarding Patient's care in progress

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5. Patient/Guardian 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 any physician, healthcare facility, other provider of health care, insurance carrier, hospital or medical service plan to provide Blue Shield or its agents or employees, and/or MPIHP all information pertaining to any illness, injury or condition, examinations or treatment, including records of billings, benefits or payments, which this patient received at any time. This information is collected to evaluate and process this request, and this authorization will expire upon the later of the completion of the request process or one year from the date of signature. The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity, and may no longer be protected under federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization and that it may be revoked at any time by submitting my revocation in writing to the entity providing the information. I may request to review and copy this form and/or the information describe in or released by this form. I understand that, except as provided in 45 C.F.R. 164.508, health care benefits, payment, enrollment or eligibility for benefits (as provided for in the applicable plan documents) may not be conditioned on whether I sign this authorization. The revocation will not have any affect on any actions or release of information taken before the revocation is received or where this authorization has already been relied upon.

Patient/Guardian Signature:______________________

If Guardian Signs, Nature of Relationship to Patient: ______________________

Date: ______________________