CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

Welcome to Kaiser Permanente:

NAME (Please Print): _____

You have made a great choice for your health! We value each and every member and aim to make your transition from your prior insurance company to Kaiser Permanente as smooth as possible. If you **are not** currently being followed by a healthcare professional for an ongoing acute medical condition listed below, please do not complete this form.

If this form applies to you, please review the steps under **"What You Need to Do"** and the alerts under **"Please Note"** so that your application can be appropriately considered for Continuity of Care.

Complete this Form:
If you are (a) currently being followed by a health care provider for any of the medical conditions listed below and or are receiving care for behavioral health and (b) would like to request approval to continue seeing that health / behavioral care provider even after beginning your coverage with Kaiser Permanente:
Please check all conditions that apply:

- ☐ 3rd Trimester Obstetric Care
- ☐ Active Oncologic (Cancer) Radiation or Chemotherapy Treatment
- ☐ Scheduled Surgery
- ☐ Hemodialysis
- ☐ Scheduled Therapy – (Physical, Occupational, and/or Speech)
- ☐ Durable Medical Equipment (DME)
- ☐ C-PAP
- ☐ Bi-PAP
- ☐ Oxygen (***except Medicare recipients on oxygen greater than > 18 months***)
- ☐ Ongoing Skilled Home Health Care
- ☐ Behavioral Health Care
- ☐ Current Inpatient or Skilled Nursing Facility Confinement

What You Need to Do:
If you are seeking continuity of care for a *Medical/Surgical issue*, complete the Patient Section on *page* 2, then give the Continuity of Care Form to your health care provider to complete. You will also need to request, and sign a Medical Release of Information Form from the provider that is treating you for this condition.

If you are seeking continuity of care for a *Behavioral Health issue*, complete the Patient Section on *page 4,* then give the Continuity of Care Form to your health care provider to complete. You will also need to request, and sign a Medical Release of Information Form from the provider that is treating you for this condition.

You do not need to complete both pages 2 *and* 4, unless you have continuity of care requests for both a medical/surgical ***and*** behavioral health issue. However, the Uniform Consultation Referral Form on page 5 must be completed by your current provider.

Ask your current health care provider who is treating your current condition to do the following:

1. Complete the Provider Section of this form
2. Complete the Uniform Consultation Referral Form
3. Sign the Continuity of Care Request Form
4. Include all relevant clinical information to support the service(s) requested
5. Include the signed Medical Release Form
6. Fax the completed Continuity of Care information packet ("What You Need to Do" items 1-7) to Medical **(855) 414-1699 or Behavioral Health (866) 311-0052 in one submission**.

Please Note:

- Incomplete and/or missing information may cause a delay in the review of your request.

CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

KAISER PERMANENTE®

- All forms must be legible; if forms are not legible, we will notify your current provider, which could delay the review of your request.
- Each member of your family who is seeking continuity of care will need to submit a separate form under his/her own name.
- Continuity of Care review is based on the information provided by you and your provider in this request. If any information should change, any previous review will become void, and a new request should be submitted immediately.
- Continuity of Care review to consider approval of continuing care is limited to the services requested and directly related to the medical condition described in the request. Services unrelated, but performed by the same physician, will not be covered.

Medical / Surgical - Review of your Continuity of Care request may be made within 3-5 business days after all pertinent clinical documentation to support this request has been received from your provider. Your current provider may contact Kaiser Permanente Utilization Management Department at **1- (800) 810-4766 option 2,** with any questions and/or concerns regarding the status of the request.

PATIENT SECTION: To be completed by the Patient (Please Print) **TODAY'S DATE:** _____
If you are unsure of insurance information, please ask your company's Human Resources Department.

Employer Group Name: _____

Kaiser Group Number: _____

Start Date of Kaiser Coverage: _____

Current Health Insurance Carrier: _____

Current Health Insurance ID Number: _____

Products:
- ☐ **HMO**
  - ☐ **HMO Signature**
  - ☐ **HMO Select**
- ☐ **DHMO**
  - ☐ **HMO Signature**
  - ☐ **HMO Select**
- ☐ **FLEXIBLE CHOICE**
- ☐ **HDHP/CDHP**
- ☐ **OOA**
- ☐ **POS**

Member Demographic:
Last Name:_____ __
First Name: _____
Middle Initial:_____ __
Date Of Birth (MM/DD/ YYYY):_____
Member Address: _____
_____
Home phone: _____
Work phone: _____
Cell phone: _____
Is it okay to leave a message? **Yes** ☐ **No** ☐
If yes, specify which number _____

PROVIDER SECTION: To be completed by Provider (Please Print)

Provider Last Name: _____ **Provider First Name:** _____ **Provider Office Phone:** _____ **Provider Office Fax:** _____	**Provider Mailing Address:** **Street:** _____ **City:** _____ **State, Zip:** _____
Type of Place for Planned Care:	**Location of Service for Planned Care:**
☐ Planned Inpatient Date of Planned Procedure / Service:_____	Facility Name & Address
☐ Current Inpatient or Skilled Nursing Facility Confinement Expected Discharge Date:_____	Facility Name, Address & Contact
☐ Outpatient Facility Date of Planned Procedure / Service:_____	Facility Name & Address
☐ Outpatient Professional Office Date of Planned Procedure / Service:_____	Provider Full Name & Office Address
☐ Ambulatory Surgical Center Facility Date of Planned Procedure / Service:_____	Facility Name & Address

CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

☐ Outpatient (Other) Describe Date of Planned Procedure / Service_____	Facility Name & Address
☐ 3rd Trimester Obstetric Care Member Expected Due Date: _____	Delivery Hospital Full Name & Address
☐ Durable Medical Equipment Date of Planned Service: _____	Vendor Name, Address, & Phone Number
☐ Skilled Home Health Care Date of Planned Service: _____	Home Health Care Agency Name, Address, & Phone Number
Diagnosis Codes - ICD 1. Code_____ 2. Code_____ 3. Code_____ 4. Code_____ 5. Code_____	 Code Description_____ Code Description_____ Code Description_____ Code Description_____ Code Description_____
Planned Procedure Codes - CPT 1. Code _____ 2. Code _____ 3. Code _____ 4. Code _____ 5. Code _____	 Code Description _____ Code Description _____ Code Description _____ Code Description _____ Code Description _____
Durable Medical Equipment - HCPCS 1. Code_____ 2. Code_____ 3. Code_____ 4. Code_____ 5. Code_____	Indicate type of equipment and how long patient has been using the equipment.
Oxygen Request - HCPCS 1. Code_____ 2. Code_____ 3. Code_____ 4. Code_____ 5. Code_____	Please include documentation of blood gas study results obtained within 30 days prior to the request.
CPAP and BiPAP Request – HCPCS 1. Code _____ 2. Code _____ 3. Code _____ 4. Code _____ 5. Code _____	CPAP and BiPAP - The following clinical documentation must be submitted. 1. CPAP Settings 2. Face-to-Face Date: (must take place first and a documentation that the beneficiary continues to use the CPAP/BiPAP device). 3. Sleep Study Test and Titrations Date:

CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

KAISER PERMANENTE®

Behavioral Health - Review of your Continuity of Care request may be made within 3-5 business days after all pertinent clinical documentation to support this request has been received from your provider. Your current provider may contact Kaiser Permanente Behavioral Health Department at **1- (301) 897-2434 option 2,** with any questions and/or concerns regarding the status of the request.

PATIENT SECTION: To be completed by the Patient (Please Print) **TODAY'S DATE:** _____

If you are unsure of insurance information, please ask your company's Human Resources Department.

Employer Group Name:
_____

Kaiser Group Number:
_____

Start Date of Kaiser Coverage:
_____

Current Health Insurance Carrier:
_____

Current Health Insurance ID Number:
_____

Products:
- ☐ **HMO**
  - ☐ **HMO Signature**
  - ☐ **HMO Select**
- ☐ **DHMO**
  - ☐ **HMO Signature**
  - ☐ **HMO Select**
- ☐ **FLEXIBLE CHOICE**
- ☐ **HDHP/CDHP**
- ☐ **OOA**
- ☐ **POS**

Member Demographic:
Last Name:_____ __
First Name: _____
Middle Initial:_____ __
Date Of Birth (MM/DD/ YYYY):_____
Member Address: _____
_____
Home phone: _____
Work phone: _____
Cell phone: _____
Is it okay to leave a message? **Yes** ☐ **No** ☐
If yes, specify which number _____

PROVIDER SECTION: To be completed by Provider (Please Print)

Provider Last Name: _____ **Provider First Name:** _____ **Provider Office Phone:** _____ **Provider Office Fax:** _____	**Provider Mailing Address:** **Street:** _____ **City:** _____ **State, Zip:** _____
Type of Place for Planned Care:	**Location of Service for Planned Care:**
☐ Planned Inpatient Date of Planned Procedure / Service:_____	Facility Name & Address
☐ Current Inpatient Facility Confinement Expected Discharge Date:_____	Facility Name, Address & Contact
☐ Outpatient Facility Date of Planned Procedure / Service:_____	Facility Name & Address
☐ Outpatient Professional Office Date of Planned Procedure / Service:_____	Provider Full Name & Office Address
Diagnosis Codes – DSM / AXIX Codes 1. Code_____ 2. Code_____ 3. Code_____ 4. Code_____ 5. Code_____	 Code Description_____ Code Description_____ Code Description_____ Code Description_____ Code Description_____
Planned Procedure Codes – DSM /AXIX Codes 1. Code _____ 2. Code _____ 3. Code _____ 4. Code _____ 5 Code _____	 Code Description _____ Code Description _____ Code Description _____ Code Description _____ Code Description _____

CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

KAISER PERMANENTE®

Uniform Consultation Referral Form

Date of Referral:	Carrier Information: Name: Kaiser Permanente
Patient Information:	
Name: (Last First, MI)	Address:
Date of Birth: (MM/DD/YY) / Phone: ( )	Phone Number:
Member #:	Facsimile/Data **(301) 388 - 1637**
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number:	Facsimile/ Data Number:	

Consultant/Facility Provider

Name: (Last, First, MI)	Specialty:	
Institution/Group:	Provider ID#: 1	Provider ID#: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number:	Facsimile/ Data Number:	

Referral Information:

Reason for Referral:		
Brief History, Diagnosis, Test Results:		
Services Desired: Provide Care as Indicated: ☐ Initial Consultation Only: ☐ Diagnostic Test: (specify) _____ ☐ Consultation With Specific Procedures: (specify) _____ _____ ☐ Specific Treatment: ☐ Global OB Care & Delivery ☐ Other: (Explain)		Place of Service: ☐ Office ☐ Outpatient Medical/Surgical Center * ☐ Radiology ☐ Laboratory ☐ Inpatient Hospital * ☐ Extended Care Facility * ☐ Other: (Explain) * (Specific Facility Must be Named.)
Number of Visits: If Blank, 1 Visit is assumed.	Authorization #: (If Required)	Referral is Valid Until: (Date) _____. (See Carrier Instruction)
Signature: (Individual Completing This Form)	**Authorizing Signature:** (If Required)	

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

Please provide the corresponding diagnosis and/or procedure codes for the requested service:

Continuity of Care Checklist

CONTINUITY OF CARE REQUEST FORM
ATTENTION: UTILIZATION MANAGEMENT OPERATIONS CENTER
MEDICAL: FACSIMILE (855) 414-1699
BEHAVIORAL HEALTH: FACSIMILE (866) 311-0052

Completed Continuity of Care Request Form (and) Maryland Uniform Consultation Referral Form (p.3. of this packet)	☐ Yes
Signed Patient Medical Release Form and attached to this submission	☐ Yes
Relevant **clinical information** to support the service/s requested attached to this submission (Pending verbiage from Ann Cahill	☐ Yes
Provider Name Print: _____ Provider Signature:_____	Date : _____