



Continuity of Care

Request Form

If you are currently receiving treatment and (i) a new WHA member or (ii) an existing WHA member whose physician has terminated with WHA, you may request to temporarily remain with your existing physician. Please see the back for more information about what continuity of care is and if you may be eligible. To request continuity of care, complete this form for each physician you want to retain. Turn this form into WHA within 30 days of enrolling (if new) or of when your physician terminated with WHA. WHA will let you know if you qualify for continuity of care.

Mail or fax form to:

WHA Member Services
2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 local
888.563.2250 toll-free
888.877.5378 tty
916.568.0126 fax

westernhealth.com

IMPORTANTE: ¿Puede leer este formulario? Si no, nosotros le podemos ayudar a leerlo. Además, usted puede recibir este formulario escrito en español. Para obtener ayuda gratuita, llame ahora mismo al Western Health Advantage (888) 563-2250 lunes a viernes de 8am - 5pm.

NOTE: Continuity of care does not apply to a new member who had the option to continue with the previous health plan provider (including an out-of-network option) and, instead, voluntarily changed health plans.

SECTION I — EMPLOYEE & PLAN INFORMATION

Employee name		Member ID#	WHA effective date	
SS#	Date of birth	Home phone	Work phone	
Address		City	State	Zip
Employer		Name of prior health insurance carrier <input type="checkbox"/> HMO <input type="checkbox"/> PPO		
Is WHA the only insurance plan offered to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you voluntarily change health plans? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION II — PATIENT, PHYSICIAN & TREATMENT INFORMATION

Patient name		Diagnosis		
Relationship to employee		Date of birth	Preferred phone	
Address		City	State	Zip
Current Primary Care Physician		Current medical group		
Current Specialist providing treatment		Type of specialty	Specialist phone	
Specialist address		City	State	Zip
Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please skip to the next row.</i>	Due date	Name of OB doctor	Hospital in which patient wishes to deliver	
Date of initial diagnosis/treatment	Is patient currently receiving treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of next scheduled treatment/appointment		
Current treatment/need (briefly describe)				

SECTION III — SIGNATURE REQUIRED

I authorize the medical providers listed above to disclose all medical records to Western Health Advantage for the purpose of reviewing my request for continuity of care. This authorization shall expire automatically after Western Health Advantage completes its review of my request. I may revoke this authorization at any time and acknowledge that a revocation will not affect records already disclosed pursuant to this authorization. I understand that both my provider and Western Health Advantage are required under state and federal law to keep my medical information confidential. I understand that Western Health Advantage will not condition my treatment, eligibility or enrollment on whether I sign this form; however, my request for continuity of care will be denied if I do not sign this authorization.

Employee signature: _____ Date: _____

OFFICE USE ONLY

<input type="checkbox"/> Approved
<input type="checkbox"/> Denied
Approved by
Date of approval

WHAT IS CONTINUITY OF CARE?

In certain circumstances (below), you may temporarily continue care with a physician who is not part of WHA's network (a "Non-Participating Provider"). If you are being treated by a provider who has been terminated from WHA's network, or if you are a new Member who has been receiving care from a Non-Participating Provider, you may continue care with that provider if you meet the continuity of care requirements explained below.

CONTINUITY OF CARE REQUIREMENTS

In order for you to be eligible for continued care, the Non-Participating Provider must have been treating you for one of the conditions listed below. Individual circumstances will be evaluated by the Medical Director on a case-by-case basis.

- An acute condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- A serious chronic condition: a serious chronic condition is a medical condition due to disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Covered services will be provided for the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by WHA in consultation with the member and the terminated provider or Non-Participating Provider, consistent with good professional practice. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly enrolled member.
- A pregnancy. Care will be continued for the duration of the pregnancy and the immediate postpartum period.
- A terminal illness: an incurable or irreversible condition that has a high probability of causing death within one year. Care shall be continued for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and thirty-six (36) months. Care shall be continued for up to twelve (12) months.
- Performance of surgery or other procedure that has been authorized by WHA (or its contracted medical group) as part of a documented course of treatment that is to occur within one hundred eighty (180) days.

NOTE ABOUT PROVIDERS

WHA and/or the medical group may require the Non-Participating Provider to agree to WHA's credentialing, hospital privileging, utilization review, peer review, quality assurance and compensation terms. If the Non-Participating Provider does not comply with these contractual terms and conditions, you will not be eligible to continue care with that provider.

IMPORTANT EXCEPTION

Continuity of care does not apply to a new member who had the option to continue with the previous health plan provider (including an out-of-network option) and, instead, voluntarily changed health plans.

To request a copy of Western Health Advantage's continuity of care policy, please call our Member Services Department at one of the numbers listed below.