Blue Shield of California
An Independent Member of the Blue Shield Association

REQUEST FOR CONTINUITY OF CARE SERVICE FOR NEW Access+ HMO ENROLLEES

Please complete all sections and return this signed form with a copy of your Blue Shield enrollment form (when enrollment is not submitted electronically) to:

Blue Shield of California
P.O. Box 272540, Chico, CA 95927-2540
(800) 424-6521

1 – *Employer & Employee Identification*

Employee Name	Employee Date of Birth _____ / _____ / _____	Member ID #
Effective Date on the Plan: Group #	Day Time Phone #: ( ) –	Home Phone #: ( ) –
Mailing Address City	State	Zip Code
Employer Name		
Employer Address		

2 – *Patient Identification*

Patient Name	Date of Birth _____ / _____ / _____	Relationship to Employee: ☐ Self ☐ Child ☐ Spouse ☐ Domestic Partner
Patient's Day Time Phone ( ) –		
Name of Patient's Blue Shield HMO Personal Physician	Phone ( ) –	
Name of Patient's IPA/Medical Group		

3 – *Prior Health Plan Coverage Information*

Name of health plan prior to Blue Shield	
Prior Health Plan identification number:	Subscriber Name:
Was your prior health care coverage HMO? ☐ Yes ☐ No If Yes, name of the IPA/Medical Group	
Was your prior health care coverage PPO? ☐ Yes ☐ No	
Is the patient currently covered by a second health plan? ☐ Yes ☐ No If Yes, health plan identification number	
Name of health plan	
Address of health plan	
Phone: ( ) –	

4 – *Medical Information*

Name and address of current attending physician, specialist, or midwife:

Attending Physician's Phone ( ) -	Fax ( ) -

Condition or Diagnosis being treated:

Is patient hospitalized now? ☐ Yes ☐ No If yes, name and address of the hospital.

Is patient on Medical Leave of Absence (LOA)? ☐ Yes ☐ No On Medical Disability? ☐ Yes ☐ No

Are you requesting continued care for a child who is newborn to 36 months of age? ☐ Yes ☐ No

Is the patient scheduled for medical treatment on either an inpatient or outpatient basis? ☐ Yes ☐ No
If yes, provide the scheduled date, name of the physician/hospital, and describe the planned treatment.

Is the patient currently receiving home health or hospice care? ☐ Yes ☐ No If yes, name and address of the home healthcare agency or hospice provider.

Does the patient have a terminal condition? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery?_____
Name and address of hospital:

Is the patient currently receiving home medical equipment ☐ Yes ☐ No If yes, name and address of the home medical equipment provider.

5 – *Additional Information You Wish To Be Considered*

6 – *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, health care facility, other provider of health care, insurance carrier, hospital or medical service plan to provide Blue Shield, or its agents or employees, all information pertaining to any illness, injury or condition, examination 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.

Subscriber Signature: _____ Date: _____

Patient Signature: _____ Date: _____

To assist us in processing your request, please attach a copy of your Blue Shield enrollment form.

Blue Shield Office use only:	
Sales Representative Name:	Phone:
Service Representative Name:	Ext.
Employer Group Number:	Health Plan Effective Date:
IPA/Medical Group Name:	