Care Continuity and Support Application Form

Please complete the entire form.

Subscriber and Plan Information

Subscriber Name		ID# (if known)	Social Security #	
Address		City	State	Zip
HCH Plan effective date	Group #	Home phone	Work phone	Mobile phone
Employer Name		Prior Insurance (if applicable)	Prior Provider (if applicable)	

Current/Proposed Course of Treatment

1. Is the patient more than 20 weeks pregnant?	Yes	No
2. If yes, when is the due date? _____ (mm/dd/yyyy)	Yes	No
2b. Has the pregnancy been diagnosed as a high-risk pregnancy?	Yes	No
3. Is the patient currently receiving treatment for an acute condition (i.e. heart attack or unstable chronic conditions) or trauma?	Yes	No
4. Is the patient scheduled for surgery or hospitalization during the next 90 days?	Yes	No
5. Is the patient being treated with a course of chemotherapy, radiation therapy, other cancer treatments, or follow-up surgery?	Yes	No
6. Is the patient diagnosed with a terminal illness or in a palliative care or hospice care program?	Yes	No
7. Is the patient receiving treatment because of a recent major surgery?	Yes	No
8. Is the patient receiving mental health or substance abuse treatment?	Yes	No
9. Is the patient approved for transplantation, approved and currently waiting for a transplant organ, placed on a transplant list, or received an organ or bone marrow transplant?	Yes	No
10. Has the patient been authorized for surgery?	Yes	No

Patient, Provider, and Treatment Information

Patient Name	Relation to Subscriber	Date of Birth	Phone	
Address (if different from Subscriber)	City	State	Zip	
Name of Terminating Insurance Plan		Plan Type (PPO, HMO)		
Current Treating Physician/Provider	Treating Physician's Phone	Specialty		
Current Treating Physician/Provider's Address	City	State	Zip	
How long has current Physician/ Provider treated the patient?	Date of Admission (if applicable)	Date of Surgery (if applicable)	Type of Surgery (if applicable)	

New HCH Health Plan in-network Primary Care Physician, if applicable.
Nature of Illness/Comments (Describe condition being treated including diagnosis, expected treatment duration and dates of surgery, if scheduled.) If Question 8 is 'yes', then provide the specific DSM-5 diagnostic criteria. Please use a separate sheet for additional comments.

Provider Signature		
Name of treating physician or other health care provider (please print)	Phone	
Address of treating physician or other health care provider (please print)	Tax ID Number	
City	State	Zip
Signature of treating physician or other health care provider	Date (mm/dd/yyyy)	

Patient Information and Communication Consent		
I authorize the above provider to give Healthcare Highways Health Plan all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that I am entitled to a copy of this authorization form.	Yes	No
I authorize Healthcare Highways Health Plan to leave confidential information on my voice mail. Please check preferred voice mail(s). _____ Home phone _____Work phone _____Mobile phone _____Please contact ONLY ME with information.	Yes	No

Patient Signature	
Signature of Patient if age 18 or older:	Date:
Signature of Parent or Guardian if Patient is under age 18:	Date:

NOTES:
(1) A separate Continuity of Care and Support Application Form must be completed for each condition for which you and/or your dependents are requesting Continuity of Care benefits. Please ensure all questions are answered completely. Please ensure this form is signed by the patient seeking the Continuity of Care benefits.
(2) Please mark your envelope "Confidential" before mailing.
(3) Please return this form as soon as possible to:
Healthcare Highways, P.O. Box _____ Frisco, TX 75034, Attn: _____.

Internal Use Only:		
Processed by:	Approved by:	Date Approved: