Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

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

REQUEST FOR CONTINUITY OF CARE SERVICE FOR ESTABLISHED MEMBERS

Complete all sections and return this signed form to:

Blue Shield of California
P.O. Box 272540, Chico, CA 95927-2540
1-800-424-6521

Section 1 – *Subscriber Information*

Subscriber Name	Subscriber Date of Birth _____ / _____ / __________	Subscriber ID #
Mailing Address City	State	Zip Code
Home Phone # ( ) –	Daytime Phone # ( ) –	

Section 2 – *Patient Information*

Patient Name	Date of Birth _____ / _____ / __________	Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse/Domestic Partner
Patient's address and daytime phone number if different from above: ____________		
Name of patient's Blue Shield Personal Physician	Physician's Phone Number ( ) –	

Section 3 – *Medical Information*

Physician(s) from whom the member is requesting continued care:

______________________________ ______________________________

Address ______________________________ ______________________________ ______________________________ Phone # ( ) –	Address ______________________________ ______________________________ ______________________________ Phone # ( ) –

Condition or diagnosis being treated: ______________________________

____

Has the member received any medical treatment from the provider who is leaving the Blue Shield network of providers in the last 30 days? ☐ Yes ☐ No

If yes, please list the medical treatment received: ______________________________

____

Does the member have routinely scheduled visits with a physician for either monitoring or treatment of a medical condition including prescription medications?

☐ Yes ☐ No If yes, please list the physician and treatment (including prescription medications) being received. ______________________________

____

____

____

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

Section 3 – *continued*

Is the member pregnant? ☐ Yes ☐ No If yes, what is the expected date of delivery? ______

Name of hospital ______

Name and address of the attending physician/midwife ______

Is the member currently hospitalized? ☐ Yes ☐ No If yes, name and address of hospital ______

Is the member scheduled for medical treatment on either an inpatient or outpatient basis? ☐ Yes ☐ No

If yes, provide the date scheduled, physician/hospital, and describe planned treatment ______

Is the member currently receiving home health or hospice care? ☐ Yes ☐ No If yes, name and address of the Home Health Care Agency or Hospice: ______

Does the member have a terminal condition: ☐ Yes ☐ No

Section 4 – *Additional information to be considered*

______

Section 5 – *Member 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.

Name of Member Responding: ______

Member Signature: ______ Date: ______

Phone number where we may reach you: ______