Blue Cross and Blue Shield of Louisiana
HMO Louisiana

Do you want to continue receiving care from your doctor?

Request for Benefits for Continuity of Care

Blue Cross and Blue Shield of Louisiana | HMO Louisiana, Inc.

What Is the Purpose of This Form?

At Blue Cross and Blue Shield of Louisiana or our subsidiary HMO Louisiana, Inc., we understand that sometimes doctors or other providers leave our networks while they are still treating some of our members. In certain cases, we allow members to have benefits to continue receiving services from their doctors or providers who are no longer in the network (an out-of-network provider).

You may have the right to continue to go to an out-of-network provider for a limited time. If approved, you could see that provider until the course of treatment is complete or 90 days after we notified you the provider is leaving the network, whichever comes first.

With your provider's help, fill out the *Request for Benefits for Continuity of Care* to ask us to consider your case. Once you send us your completed form, we will carefully review your case. After we reach a decision, we will notify both you and your provider.

Under What Conditions Can You Qualify for Benefits to Continue Care?

To qualify for benefits to continue care, you must be:

- **Undergoing active treatment for an acute, chronic, or serious and complex condition;** or
- **In the hospital or under inpatient care;** or
- **Scheduled for a non-elective surgery or procedure by the provider or in postoperative care;** or
- **Pregnant and undergoing a course of treatment for the pregnancy;** or
- **Terminally ill, which means your life expectancy is 6 months or sooner, and undergoing care for the terminal illness from the provider.**

When Will We Deny Benefits to Continue Care?

If your provider tells us that you meet any of the criteria listed, we may approve benefits for you to continue care with that provider.

But we will not approve benefits to continue care if:

- Your provider was terminated from the network because your provider's license to practice in Louisiana was suspended or revoked or for another documented reason related to quality of care; or
- Your provider was terminated from the network because of fraud; or
- You choose to change providers; or
- You move out of our geographic service area; or
- You do not meet the health conditions listed on this form to qualify for benefits to continue care from an out-of-network provider.

Still have questions?

Call us. We will be happy to help you.

Call Care Management at: 1-800-317-2299

 Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana Inc., are independent licensees of the Blue Cross Blue Shield Association.

Request for Benefits for Continuity of Care

Blue Cross and Blue Shield of Louisiana | HMO Louisiana, Inc.

If you are a member of Blue Cross and Blue Shield of Louisiana or our subsidiary HMO Louisiana, Inc., and you want to continue care with your doctor even though your doctor is no longer in our network, fill out Part 1 of this form. Then give the form to your doctor or provider to fill out Part 2 before you send it to us.

Part 1: Information for You, the Member

Your name
As shown on your Blue Cross ID card

Your mailing address

Street

City | State | ZIP code

Your date of birth

___ /___ /_____
MM / DD / YYYY

Your Blue Cross ID number
As shown on your ID card

Are you …

- ❑ The Subscriber?
- ❑ A Spouse?
- ❑ A Dependent?

Read this and sign below:

I understand and agree to the terms described in this form.

I know that Blue Cross considers each case individually, and that this request is only to treat the specific health condition or to obtain the specific service explained in this form.

Usually, to receive benefits according to my contract, I must go to doctors or providers in my network. My contract explains any limitations or exclusions of my plan.

Any approval you may give me to continue care with my doctor or provider is temporary. If you approve my request, it will last for up to 90 days. You are only providing network level of benefits so I can continue to go to my doctor or provider who is no longer in the network for a specific health condition or service. You are not extending benefits in my contract for any other reason or in any other manner.

Your signature

Today's date

___ /___ /_____
MM / DD / YYYY

Part 2: Information for Your Doctor or Provider

Doctor's or Provider's name

Doctor's or Provider's mailing address

Street

City | State | ZIP code

Doctor's or Provider's phone number

( ) –

What is your patient's medical condition?

	Is the patient pregnant?	❑ No ❑ Yes. Due date: ___ /___ /_____ MM / DD / YYYY
What is the diagnosis?		
	ICD-10 code?	
What is the patient's current treatment plan? Include any narratives or copies of medical records that will help us evaluate this case.		
	How long do you estimate that the patient needs your services?	
	Are other providers now involved in your patient's care?	❑ No ❑ Yes. List them

Read this and sign below:

I understand and agree to the terms described in this form.

I understand that if Blue Cross approves this request, you will continue to pay me under the same terms and conditions of the physician agreement that was in effect before the qualifying event occurred.

Also, for any covered services, I will accept your payment, plus the member's deductible, coinsurance and copayment, if they apply. I will not bill the patient more than the allowable charge for covered services.

I will follow Blue Cross' utilization management and quality management policies and procedures for the period during which the patient receives continuity of care services.

My signature		**Today's date**	___ /___ /_____ MM / DD / YYYY

After the form is complete, send it to us, along with any other information we requested.

Fax it to us at: **1-800-267-6548**

Mail it to us at: **Care Management Services**
Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

Nondiscrimination Notice

Discrimination Is Against the Law

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana, Inc. and Southern National Life, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Louisiana Blue does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Louisiana Blue and its subsidiaries:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, you can call the Customer Service number on the back of your ID card or email MeaningfulAccessLanguageTranslation@lablue.com. If you are hearing impaired call 1-800-711-5519 (TTY 711).

If you believe that Louisiana Blue or one of its subsidiaries failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to take the following steps:

1. If you are fully insured through Louisiana Blue or one of its subsidiaries, file a grievance in person or by mail, fax or email.

   Section 1557 Coordinator
   In Person: 5525 Reitz Ave. Baton Rouge, LA 70809
   Mail: P. O. Box 98012, Baton Rouge, LA 70898-9012
   Phone: (225) 298-7238 or 1-800-711-5519 (TTY 711)
   Fax: (225) 298-7240
   Email: Section1557Coordinator@lablue.com

2. If your employer sponsors a self-funded health plan and Louisiana Blue only serves as the Claims Administrator, contact your employer or your company's Human Resources Department. To determine if your plan is fully insured by Louisiana Blue or self-funded and sponsored by your employer, go to **www.lablue.com/checkmyplan**.

Whether you are fully insured or covered by a self-funded health plan, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Mail: 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD)

This notice is available at www.lablue.com.

Blue Cross and Blue Shield of Louisiana and its subsidiaries, HMO Louisiana Inc. and Southern National Life Insurance Company Inc., are independent licensees of the Blue Cross Blue Shield Association.

NOTICE

Free language assistance services and auxiliary aids are available. If needed, please call the Customer Service number at 1-800-495-2583. Hearing-impaired customers call 1-800-711-5519 (TTY 711).

Tiene a su disposición servicios de asistencia lingüística y ayudas auxiliares gratuitas. Si necesita ayuda, llame al Servicio de Atención al Cliente al 1-800-495-2583. Los clientes con discapacidad auditiva pueden llamar al 1-800-711-5519 (TTY 711).

Des services d'assistance linguistique gratuits et des aides auxiliaires sont disponibles. Si nécessaire, veuillez appeler le numéro du service client au 1-800-495-2583. Les clients malentendants peuvent appeler le 1-800-711-5519 (ATS 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện hỗ trợ. Nếu cần, vui lòng gọi Dịch vụ khách hàng theo số 1-800-495-2583. Khách hàng khiếm thính vui lòng gọi 1-800-711-5519 (TTY 711).

免费提供语言协助服务和辅助工具。如有需要，请拨打客户服务电话 1-800-495-2583。听障客户请拨打 1-800-711-5519 (TTY 711)。

تتوفر خدمات مساعدة لغوية ووسائل مساعدة إضافية مجانية. وفي حال الحاجة إلى هذه الخدمات، يُرجى الاتصال بخدمة العملاء على الرقم 1-800-495-2583. يُرجى من العملاء ذوي الإعاقة السمعية الاتصال على الرقم 1-800-711-5519 (خدمة الهاتف النصي 711).

Mayroong mga libreng serbisyo sa tulong sa wika at karagdagang tulong. Kung kailangan ito, mangyaring tawagan ang numero ng Serbisyo sa Customer sa 1-800-495-2583. Para sa mga customer na may kapansanan sa pandinig, tumawag sa 1-800-711-5519 (TTY 711).

무료 언어 지원 서비스와 보조 도구를 이용하실 수 있습니다. 필요한 경우 고객 서비스 번호 1-800-495-2583으로 전화해 주시기 바랍니다. 청각 장애가 있는 고객은 1-800-711-5519(TTY 711)로 전화하십시오.

Serviços de assistência de idioma e demais auxílios disponíveis gratuitamente. Se necessário, ligue para o Atendimento ao Cliente no telefone 1-800-495-2583. Clientes com deficiência auditiva devem ligar para 1-800-711-5519 (TTY 711).

ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ເຄື່ອງຊ່ວຍເສີມຟຣີ. ຖ້າຕ້ອງການ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າ ທີ່ເບີ 1-800-495-2583. ລູກຄ້າທີ່ພິການຫູ ໃຫ້ໂທຫາ 1-800-711-5519 (TTY 711).

無料の言語アシスタンスサービスと介助用補助具をご利用いただけます。必要な場合は、カスタマーサービス番号1-800-495-2583までお電話ください。聴覚に障害のあるお客様は、1-800-711-5519 (TTY 711)までお電話ください。

زبان کے سلسلے میں مفت معاونت کی سہولیات اور اضافی معاونتیں دستیاب ہیں. ضرورت پڑنے پر کسٹمر سروس سے ان نمبر پر رابطہ کریں: 1-800-495-2583. سماعت کی کمی کے شکار افراد اس نمبر پر کال کریں: 1-800-711-5519 (TTY 711)

Bei Bedarf stehen Ihnen kostenlose Sprachhilfen und andere unterstützende Dienste zur Verfügung. Bitte wenden Sie sich dazu telefonisch an den Kundenservice unter 1-800-495-2583. Sollten Sie schwerhörig sein, wählen Sie bitte die 1-800-711-5519 (TTY 711).

خدمات کمک زبانی رایگان و ابزارهای کمکی جانبی در دسترس هستند. در صورت نیاز، لطفاً با «خدمات مشتریان» به شماره 1-800-495-2583 تماس بگیرید. مشتریان کم‌شنوا با 1-800-711-5519 (TTY 711) بگیرند.

Мы предоставляем бесплатные услуги языковой поддержки и вспомогательное оборудование. При необходимости позвоните в службу поддержки клиентов по номеру 1-800-495-2583. Телефон для клиентов с нарушениями слуха — 1-800-711-5519 (TTY 711).

มีบริการช่วยเหลือด้านภาษาและเครื่องสนับสนุนฟรี หากจำเป็น โปรดโทรติดต่อฝ่ายบริการลูกค้าได้ที่หมายเลข 1-800-495-2583 ลูกค้าที่มีความบกพร่องทางการได้ยิน โปรดโทรไปที่หมายเลข 1-800-711-5519 (TTY 711)