Louisiana

HMO Louisiana

Do you want to continue care with 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 leave our networks while they are still treating some of our members. In special cases we allow members to have benefits to continue seeing their doctors or providers who are no longer in the network.

If we do approve benefits to continue seeing an out-of-network healthcare provider, we limit how long you may continue to go to that provider.

With your doctor'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 healthcare provider.

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

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

- **An ongoing course of treatment for a *life-threatening condition***);
- **An ongoing course of treatment for a *serious acute condition*** (Your disease or condition needs complex ongoing care that you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits);
- **A high-risk pregnancy or are in the second or third trimester of pregnancy**, through the postpartum period; or
- **An ongoing course of treatment for a condition for which your doctor proves that if your care is stopped, your condition would worsen or expected outcomes would be delayed**.

Note: For an *active course of treatment*, an *ongoing course of treatment* includes treatments for mental health and substance use disorders that fall within the definition of active course of treatment. Benefits to continue care will be at in-network cost-sharing rates for up to 90 days or until treatment is completed, whichever is shorter.

When Will We Deny Benefits to Continue Care?

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

But we will not approve benefits to continue care if:

- Your doctor was terminated from the network because your doctor's license to practice in Louisiana was suspended or revoked or for another documented reason related to quality of care,
- You choose to change doctors,
- You move out of our geographic service area, or
- You need only routine monitoring for a chronic condition but you are not in an acute phase of the condition.

Still have questions?

Call us. We will be happy to help you.

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

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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 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		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 explained in this form.

Usually to receive benefits according to my contract, I must go to 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 is temporary. If you approve my request, it will last for up to 90 days. You are only providing in-network level of benefits so I can continue to go to my doctor who is no longer in the network. You are not extending benefits in my contract for any other reason.

Your signature		Today's date	____/____/_____ MM / DD / YYYY

Part 2: Information for Your Doctor

Doctor's name					
Doctor's mailing address	Street				
			State		ZIP code
Doctor's phone number	( ) –				
What is your patient's medical condition?					
Is the patient	❑ 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's 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: (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