CONTINUITY OF CARE REQUEST FORM

This is a formal request to continue care with a provider that is terminating from the Alliant Health Plans network.

The request determination will be returned by mail. If your request is not approved, any services rendered by the provider will be paid at the out-of-network benefit status.

Member: Please complete the following section (please print all information):

1. Member Information (member ID number, DOB, etc.) You will find this information on the front of your insurance ID card.
2. Authorization. Please carefully read the authorization, sign and date the form. Please note, the member must sign and date the form. If the member is under 18 years old, an authorized representative of the minor member must also sign and date the form.

After you have completed the first 2 sections of information on this document, give the form to your provider to complete sections 3 and 4. The provider's office may then fax the document to Alliant Health Plans (866-634-8917) for review.

STEP ONE: Member Information

Name:
Date of Birth: MM/DD/YYYY
Alliant Health Plans ID number:
Member Phone Number:

STEP TWO: Authorization (PLEASE READ)

I request approval for coverage of ongoing care (continuity of care) from the healthcare provider named below in section 4 for treatment that began prior to the end of the provider's contract with Alliant Health Plans. I understand that if the authorization for coverage of services is approved it will be for a limited period of time. I give permission for the health care provider to submit any needed medical information and/or records to Alliant Health Plans for review and decision.

Member Signature and Date: (for 18 and older)
Legal Guardian Signature and Date: (for 17 and younger)

STEP THREE: Provider Information (give to your provider for completion)

Provider Name:	
Provider Phone Number:	Provider Tax ID:
Provider Address:	

Note to Provider: The above named member is an Alliant Health Plans' member. Although you are not currently a participating provider for Alliant Health Plans the member has requested that we cover care provided by you for a limited and specific amount of time. In order to determine whether the member's request for continuation of coverage can be approved, we need to review clinical information.

Continuation of coverage may be allowed if the following criteria are met:

1. Period of active treatment for members undergoing active treatment for a chronic or acute medical condition.
2. Members in their second or third trimester of pregnancy (through the postpartum period)

Please enter the requested information below, and attach any clinical information that may be helpful in making the continuation of coverage decision.

Diagnosis:
If pregnant, EDD:
Treatment plan (not necessary if pregnant):
Start/end date of treatment:

Provider Agreement

I request approval for coverage of ongoing care (continuity of care) for the member named above for treatment that was started before the end of my provider contract with Alliant Health Plans. I understand that if the authorization for coverage of services is approved it will be for a limited period of time. I agree to abide by the terms of my provider contract and continue to provide services for the above member for the agreed-upon time period at the contract rate. I agree not to seek payment from the member for any amount the member would not be responsible for as an in-network provider, to share information regarding the treatment plan with Alliant Health Plans and to use the Alliant Health Plans' network providers for any necessary referrals, hospitalizations, lab work or diagnostics.

Once received and reviewed by Alliant Health Plans, notice will be sent via US Mail of the decision. If continuing coverage is not approved, any covered services provided to the member will be paid as out-of-network benefit.

Provider Signature	Date: MM/DD/YYYY