Request for Continuity of Care Benefits

Fax: (619) 740-8570
Phone: (858) 499-8300

If you or a member of your family are currently being treated for an acute health condition, high risk pregnancy, or are in the second or third trimester of your pregnancy, please complete the attached form so we can assist in the coordination of health care services. One of our case managers will review the information you've provided, and contact you to assist with any needs.

Please complete this form in its entirety and return to Sharp Health Plan, 8520 Tech Way, Suite 200, San Diego, CA 92123, or fax to 619-740-8570.

Incomplete forms will be returned for missing information and will result in the delay in processing this request.

SUBSCRIBER AND PLAN INFORMATION			
Subscriber Name:		**SSN:**	
Address:		**State:**	**Zip:**
Home Phone:	**Work Phone:**		
If needed, may we call you at home? ☐ **Yes** ☐ **No**	**At work?** ☐ **Yes** ☐ **No**		
Prior Insurance (if any):	**Name of your Employer:**		
Is enrollment with Sharp Health Plan contingent upon the approval of this Continuity of Care? ☐ **Yes** ☐ **No**			

PATIENT, PHYSICIAN AND TREATMENT INFORMATION			
Patient Name:		**Date of Birth:**	
Relationship to Subscriber: ☐ **Self** ☐ **Spouse** ☐ **Son** ☐ **Daughter** ☐ **Other:**			
Current Physician:		**Specialty:**	
Address:	**City:**	**State:**	**Zip:**
Phone:			
Condition(s) being treated:			
How long with this physician:			
Treatment received for this condition:			
Expected due date:	**Delivery Hospital (if pregnant):**		
Current Medication(s):	**Dosage(s):**		

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. If you are requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you will be provided with separate authorization forms which have been adopted to comply with the heightened protections for these treatment records afforded by federal and state laws. To obtain one of these forms or if you have any questions regarding Continuity of Care Benefits, please contact Sharp Health Plan's Customer Service Department at 1-800-359-2002.

AUTHORIZATION. I hereby authorize _____ (name of physician or health care provider) to furnish to Sharp Health Plan medical records and information pertaining to medical history, medical condition, services rendered, or treatment of _____ (name of patient). This information will be used solely by Sharp Health Plan in order to evaluate the request for Continuity of Care Benefits. I understand that Sharp Health Plan may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. This authorization shall become effective immediately and shall remain in effect until (month/day/year) _____, _____. I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested: ☐ Yes ☐ No

I understand that this request for Continuity of Care Benefits will be reviewed by Sharp Health Plan through its regular and appropriate utilization review process, and administered consistent with my Sharp Health Plan benefit plan. I will receive written approval or denial of this request from Sharp Health Plan. I understand that the requested services are not approved by Sharp Health Plan unless specifically authorized in a written notification from the Plan. I also understand that if my request is denied, I have the right to appeal that decision.

Print Name of Patient: _____ Date: _____

Signature of Patient: _____