Request for Continuity of Care

Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123
FAX (619) 740-8111
TEL (858) 499-8300

Continuity of Care means continued services with a health care provider you were seeing before you enrolled in Sharp Health Plan. If you or a member of your family are currently being treated by a provider who is not contracted with your Sharp Health Plan Network, you may be eligible to complete your care with this provider under certain circumstances. Continuity of Care may also apply if you are a current Sharp Health Plan member and your health care provider is no longer contracted with Sharp Health Plan.

Continuity of Care may be provided for the completion of care when a member is in an active course of treatment for the following conditions: (1) an acute condition; (2) a serious chronic condition; (3) a pregnancy; (4) a terminal illness; (5) a pending surgery or procedure that was previously scheduled; or (6) a child age 0-36 months.

If you are a newly enrolled member and you had the opportunity to enroll in a health plan with an out-of-network option, you are not eligible for continuity of care. If you had the option to continue with your previous health plan but instead voluntarily chose to change health plans, you are not eligible for continuity of care.

If you would like to request continuity of care benefits, please complete the both sides of this form so we can assist in the coordination of health care services. Return the completed form to Sharp Health Plan, 8520 Tech Way, Suite 200, San Diego, CA 92123, or fax to 619-740-8111. One of our case managers will review the information you've provided, and contact you to assist with any needs.

Please submit a separate form for each provider from whom you are requesting services.
Incomplete forms will be returned for missing information and will result in a delay in processing this request.

PATIENT, PROVIDER AND TREATMENT INFORMATION			
Patient Name:		**Date of Birth:**	
Relationship to Subscriber: Self Spouse Son Daughter Other:			
Current Provider:		**Specialty:**	
Name of Provider You are Requesting:		**Facility:**	
Address of Current Provider:	**City:**	**State:**	**Zip:**
Phone of Current Provider:			
Condition Currently Being Treated:			
Treatment Received for This Condition:			
Date of Most Recent Visit to This Provider:			
Address of Provider You are Requesting:	**City:**	**State:**	**Zip:**
Phone Number of Provider You are Requesting:			
Date of Most Recent Visit to This Provider:			
Do You Have an Appointment Scheduled? Yes No **If Yes, What is the Date of Your Appointment?**			
Did You Have Surgery Within the Past Year or Do You Have a Surgery Scheduled? Yes No **If Yes, Please Specify Type of Surgery and Date.**			
Expected Due Date (if pregnant):	**Delivery Hospital (if pregnant):**		

SUBSCRIBER AND PLAN INFORMATION			
Subscriber Name:		**Subscriber Date of Birth:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**		
If needed, may we call you at home? Yes No	**At work?** Yes No		
Name of Prior Insurance:	**Name of Current Employer:**		
Effective Date with Sharp Health Plan:			
Name of Person Completing This Form:	**Relation to Patient:**		

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By completing this document, you authorize the disclosure and/or use of your individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information may invalidate this Authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION. 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 Authorization applies to the following information (select one of the following options):

☐ **All Health Information** including diagnosis, providers, treatments, and drugs

☐ **Only Limited Information**

Specify type of information: _____

Specify date range: _____

Federal and State laws require us to obtain specific authorization to release especially sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results, psychiatric care, and treatment for alcohol or drug abuse. We will automatically try to exclude these types of information unless you specifically identify them for release. Please check below if you authorize Sharp Health Plan to release any or all of the following sensitive information.

☐ **I also specifically authorize the release** of the following types of sensitive information (check all that apply):

☐ Psychiatric Care ☐ Substance Abuse Treatment ☐ HIV and AIDS Test Results

EXPIRATION. This authorization will expire on **(month/day/year)** _____. If no expiration date is selected, this document will be in effect until I send a written request to revoke this authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization.
- I may revoke this authorization at any time by notifying Sharp Health Plan in writing. My revocation will be effective upon receipt but will not be effective to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- I understand that Sharp Health Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization, except under limited circumstances described in the Notice of Privacy Practices.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and might not be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.
- I understand that Sharp Health Plan may not use or disclose my PHI other than for the purposes described on this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- I hereby release Sharp Health Plan from any and/all liability that may arise from the release of this information to the party named on this form.

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 writing. 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: _____

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Internal Use Only

Date Received: _____