CONTINUITY OF CARE APPLICATION

UCLA Health | Medicare ADVANTAGE PLAN

Plan effective date: _____

This form is for UCLA Health Medicare Advantage Plan (UHMAP) members with ongoing health care needs. This information will assist us in transitioning your care when you become effective with the plan. Please complete all sections of this form. Thank you.

General Information			
Please select one: ☐ New UHMAP Member ☐ Existing UHMAP Member Whose Provider Is No Longer on Plan			
Member Name:		Member Date of Birth (mm/dd/yyyy):	
Relationship to Member: ☐ Self ☐ Spouse ☐ Child			
Cell Phone (including area code):		Home Phone (including area code):	
Mailing Address:		City:	
State:	Zip:	Email Address:	
Employer:			
Select your UHMAP plan: ☐ Principal ☐ Prestige		Primary Care Provider:	
Are you covered by any other health insurance, including Medicare? If so, please complete the information below:			
Insurance Carrier:		Plan Name:	
Group #:		Policy #:	

Medical Information		
1	Have you been hospitalized in the past year? ☐ Yes ☐ No	
	If yes, what were you hospitalized for?	
2	Do you expect to be in the hospital when coverage with UHMAP begins or in the next 90 days? ☐ Yes ☐ No	
3	Are you currently being treated for any illness or condition? ☐ Yes ☐ No	
	If yes to the above, please list the illness and conditions below, as well as the treating provider(s) for each.	
	Illness or Condition:	**Treating Provider:**
	1)	
	2)	
	3)	
4	Do you have a surgery scheduled after your effective date of coverage? ☐ Yes ☐ No	
	If yes to the above, what type of surgery?	
	If yes to the above, when is your surgery scheduled?	
	If yes to the above, who is your surgeon?	
	If yes to the above, where is your surgery taking place?	
5	Are you scheduled for high tech imaging? ☐ Yes ☐ No	
	If yes to the above, when is your high-tech imaging scheduled?	

	If yes to the above, where is your high-tech imaging procedure taking place?	
	If yes to the above, who is your ordering physician?	
6	Are you pregnant? ☐ Yes ☐ No	If yes, what is your due date:
	If pregnant, who is your OB doctor?	
	If pregnant, at which hospital are you scheduled to deliver?	
	If pregnant, is your pregnancy considered high risk (e.g., twins, diabetes, age)? ☐ Yes ☐ No	
7	Are you currently receiving chemotherapy or radiation oncology therapy? ☐ Yes ☐ No	
	If yes, who is your treating doctor?	
	If yes, where are you receiving chemotherapy or radiation therapy?	
8	Are you currently receiving dialysis? ☐ Yes ☐ No	
	If yes, what type of dialysis?	
	If yes, where are you receiving dialysis?	
9	Are you currently a candidate for an organ transplant? ☐ Yes ☐ No	
	If yes, what type of organ?	
	If yes, what facility?	

Please list any questions that you may have for our nurses in regard to your transition of care.

NOTE: If you need continuity of care for ongoing general medical services including radiation and medical oncology services, have your provider fax a request to **424-234-7698**.

Prior authorization forms can be downloaded by visiting our website at: www.UCLAHealthMedicareAdvantage.org/resources

Pharmacy Information

Prior to your effective date, please make sure you have enough medication refills. Contact your primary care provider if you have any questions about your ongoing medication needs. You should understand your pharmacy benefit for generic versus brand drugs.

10	If you are currently taking a drug that requires prior authorization (approval from the health plan), do you have any questions about these?	☐ Yes ☐ No

For a complete list of the Preferred Drugs, please visit www.UCLAHealthMedicareAdvantage.org/formulary

Behavioral Health Information

For questions about your behavioral health benefits, please call UHMAP at **833-627-8252**.

Signature of Member (Required)

I hereby authorize the above provider to give UHMAP all information and medical records necessary to make an informed decision concerning my request for Continuity of Care benefits under UHMAP. I understand I am entitled to a copy of this authorization form.

Signature of Member or Appointed Representative	**Date (mm/dd/yyyy)**	**Submit your completed form to UHMAP via email to HPUM@mednet.ucla.edu OR by secure fax to: 424-234-7698.** If you need to contact Member Services call 833-627-8252. Continuity of Care requests will be reviewed within 14 days of receipt (upon effective membership). Review for organ transplant requests may take longer than 14 days.

EMAIL YOUR COMPLETED FORM TO: HPUM@mednet.ucla.edu