

## Continuity of Care Application

**READ BEFORE YOU BEGIN:** *If you changed health plans but your doctor remains with the same IPA/Medical Group, your care will continue without disruption; you do **not** need to complete this form.*

### Important Information for Members New to an HMO Plan:

When you join the UCLA Health Medicare Advantage Plan (UHMAP), you agree to receive your care through your IPA/Medical Group and its provider network. This means you agree to transition your care into your IPA/Medical Group's network, rather than continuing care with doctors outside the network, as you may have done in a PPO plan or Original Medicare.

### What is Continuity of Care?

Continuity of Care helps prevent interruptions when you are in the middle of **acute, medically necessary** treatment at the time you join UHMAP. **If approved**, it allows you to **receive temporary, time-limited coverage** for specific services from a doctor who is not in your IPA/Medical Group's network. This coverage is **transitional** and is intended solely to support a safe move of your care into your IPA/Medical Group's network.

### Purpose:

This form is intended for UHMAP members currently undergoing **acute, medically necessary treatment** who may face disruption in care due to a change in health plans or provider network status. If approved, you may be able to continue services with your current doctor on a **temporary basis only**, while your care is transitioned to an in-network doctor.

### When You Should NOT Use This Form:

This form should NOT be used if:

- You are requesting to keep a doctor solely due to preference or familiarity.
- You wish to continue long-term care with a care doctor outside your IPA/Medical Group's network.
- You are not currently receiving active treatment.

UHMAP members are expected to receive ongoing care from the chosen IPA/Medical Group and its in-network doctors after enrollment.

### Important Notes:

- This form is **not** required for all new members.
- Complete this form only if you are experiencing or expecting a disruption in active care (e.g., your current doctor is not in your chosen IPA/Medical Group network).
- You do not need to complete this form if you are looking to continue with your current prescription. Our Part D pharmacy benefit transition policy allows **new members** a 30-day supply of their medication during their first 90 days of joining our health plan. This gives you time to speak with your doctor about switching medications or getting approval to keep using the current one.

**Member certification, authorization, and signature**

☐ **I understand that submission of a Continuity of Care (CoC) request does not guarantee approval.**

Approval is subject to review and will be granted only if the request meets medical necessity criteria and eligibility guidelines established by the health plan.

☐ **I acknowledge that I am required to transition my care to an in-network provider.**

If approved, the Continuity of Care authorization is temporary and is intended solely to facilitate a safe transition of care.

Member Signature:

Date of Signature:

**Patients may ask their provider to fill in their information.**

**Mailing address:**

**UCLA Health Medicare Advantage Plan**

P.O. Box 211622

Eagan, MN, 55121-3622

**Email:** [HPUM@uhmap.com](mailto:HPUM@uhmap.com)

**Secure Fax:** 424-234-7698

**Call with questions:**

If you have any questions or would like to submit the Continuity of Care Application over the phone, please call Member Services at 1-833-627-8252 (TTY 711), Hours are 8am - 8pm PST, Monday - Friday, April 1 through September 30, except on all federal holidays. Hours are 8am - 8pm PST, 7 days a week, October 1 through March 31, except Thanksgiving Day and Christmas Day.

**Visit our website** at [www.uclahealthmedicareadvantage.org/](http://www.uclahealthmedicareadvantage.org/) for additional information.

**Type of request:**

- ☐ **Urgent/Expedited (72 hours):** This request must meet the CMS exigency standard that a delay would seriously jeopardize life or health or the ability to regain maximum function.
- ☐ **Standard:** 7 days

**This form must be finished completely to avoid a processing delay. Please print.**

|                                 |                                    |            |
|---------------------------------|------------------------------------|------------|
| Member Name (Last, First, MI):  | Member phone number:               | Member ID: |
| Policy Effective Date:          |                                    |            |
| Address (Street, City, ZIP):    |                                    |            |
| Assigned Primary Care Provider: | Member Date of Birth (mm/dd/yyyy): |            |

**Reason(s) for asking for continuity of care assistance:**

**My medical need(s) include: (Please check all that apply.)**

- |                                                      |                                                  |
|------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Scheduled procedure/surgery | <input type="checkbox"/> Specialist Office Visit |
| <input type="checkbox"/> Acute Condition             | <input type="checkbox"/> Dialysis                |
| <input type="checkbox"/> Serious Chronic Condition   | <input type="checkbox"/> Organ Transplant        |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> DME                     |
| <input type="checkbox"/> Imaging                     | <input type="checkbox"/> Other:                  |

Name of Doctor you are asking to continue services with:

Doctor's address (street, city, zip):

Doctor's phone number:

Doctor's fax number:

National Provider Identifier (if applicable):

Member's Diagnosis:

Diagnosis code (CPT):

Next scheduled appointment date:

Reason for appointment:

Have you been seen by the doctor at least once in the past 12 months? ☐ Yes ☐ No

Please tell us why you want help with your current medical care. Write down the type(s) of service(s) you are asking for:

I hereby authorize UHMAP or its delegated entities to obtain any information and medical records from the above doctor(s) in connection with making an informed decision regarding my request for Continuity of Care benefits under my new health plan.  
I understand that I am entitled to a copy of this authorization form.

Patient's signature or member's representative making the request:

Date: