UCLA Health | Medicare ADVANTAGE PLAN

Continuity of Care Application

What is Continuity of Care:

Continuity of Care is a coordinated patient care approach that ensures uninterrupted access to medically necessary services during transitions of care in health coverage or provider networks. For UCLA Health Medicare Advantage Plan (UHMAP) members, it minimizes disruptions to medically necessary treatment with an out-of-network provider at in-network benefit levels. This helps prevents delays in your care and supports your safety and ongoing treatment.

What is Transition of Care:

Transition of Care coverage lets you keep seeing a doctor or specialist who is not in the UHMAP network for a limited time if you're being treated for an **acute** health condition. This gives you time to safely move your care to a provider in our network. To qualify, you must already receive ongoing treatment for an **acute** condition listed on your request form. If approved, this coverage only applies to the condition and provider you include in your request. For all other care, you'll need to use in-network providers to get in-network benefits.

Purpose:

This form is intended for UHMAP members currently undergoing **active, medically necessary treatment** who may face a disruption in care due to a change in health plans or provider network status. If approved, you may be able to keep seeing your current doctor or facility for a limited time, even if they are no longer in-network.

- Completing this application allows UHMAP to evaluate your medical needs and determine if temporary continuation of services with your current provider is appropriate and covered under your plan benefits.
- To qualify for Continuity of Care, you must be receiving treatment for an **active** condition listed on the request form. If approved, coverage will be provided for a limited time based on your medical needs.
- Continuity of Care coverage only applies to the treatment of the medical condition specified and the healthcare provider identified on the form. All other conditions must be care for by an in-network healthcare provider.

Important Notes:

- This form is ***not*** required for all new members.
- Complete this form only if you are experiencing or expecting a disruption in care (e.g., your current provider is not in the UHMAP network).
- If you changed health plans but your provider remains with the same medical group, your care will continue without disruption; you do not need to complete this form.
- 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.

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Type of request: ☐ Urgent (1-2 Days) ☐ Immediate (Within 7 Days) ☐ Standard (More than 7 Days)

This form must be finished completely to avoid a processing delay. Please print.		
Member Name (Last, First, MI):	Member phone number:	Medicare Number:
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.)

☐ Scheduled procedure/surgery	☐ Specialist Office Visit
☐ Acute Condition	☐ Dialysis
☐ Serious Chronic Condition	☐ Organ Transplant
☐ Cancer	☐ DME
☐ Imaging	☐ Other:

Name of Provider you are asking to continue services with:		
Provider's address (street, city, zip):		
Provider's phone number:	Provider'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 provider 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 provider(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**:**

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Please return the completed Continuity of Care form to UCLA Health Medicare Advantage Plan:

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

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/ for additional information.