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A UnitedHealth Group Company

APPLICATION FOR CONTINUITY OF CARE
NORTH CAROLINA

UnitedHealthcare
Attn: Pre-Service Notification
1311 W President Bush FWY
Richardson, TX 75080-1133
Fax: 800-628-0654

Employee/Applicant:

Continuity of care may enable qualifying existing enrollees covered under UnitedHealthcare to receive care for specified medical conditions for a time-limited period from a newly non-contracted physician or facility at the benefit level associated with contracted physicians and facilities for treatment of ongoing special conditions:

1. In the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
2. In the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time.
3. In the case of pregnancy, pregnancy from the start of the second trimester.
4. In the case of a terminal illness, an individual has a medical prognosis that the individual's life expectancy is six months or less.

A transitional period shall extend up to ninety days. However this period shall be extended for the following conditions:

1. Scheduled surgery, organ transplantation and inpatient care. The transitional period shall be extended through the date of discharge after completion of the surgery, transplantation or other inpatient care and for post-discharge follow-up care occurring within ninety days after the date of discharge.
2. Pregnancy. The transitional period shall be extended through the provision of sixty days of postpartum care.
3. Terminal Illness. The transitional period shall be extended for the remainder of the individual's life.

Acceptance of this application is not a guarantee of benefits, payment or clinical coverage determination. Payment of services is based on your benefit plan at the time services are provided.

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Disclaimer: HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUITY OF CARE BENEFITS?

- Read & complete section 1 of the application.
- If you answer No to every question, you are NOT eligible for Continuity of Care. Please contact the number on the back of your ID card to have a customer care professional help you in finding a doctor in the UnitedHealthcare network.

THE APPLICATION PROCESS

1. Complete part 2 if you answered YES to any of the questions in Section 1.
   - **Proceed to Part 2 only if you answered YES to at least 1 question in Part 1.**
2. Complete part 2 of the application.
   - **Be sure to sign the authorization form to release your medical records.**
3. Have your physician complete section 3 of the application.
   - **If you are receiving care from more than one physician, each one must individually complete section 3.**
4. Mail the completed application along with relevant medical records to the address noted on the top of this application within 45 days of the date on your notification letter.

SECTION 1 TO BE COMPLETED BY APPLICANT

Are you in your second trimester of pregnancy or did you deliver less than 60 days ago?	☐ YES	☐ NO
Do you have an acute illness, that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm?	☐ YES	☐ NO
Do you have a chronic illness or condition, that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time? Examples can include AIDS and cancer.	☐ YES	☐ NO
Do you have a terminal illness with a life expectancy of 6 months or fewer?	☐ YES	☐ NO
Are you on a transplant waiting list?	☐ YES	☐ NO

SECTION 2 TO BE COMPLETED BY APPLICANT

Employee Name		Social Security Number
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name		Plan Group Number
Patient Name		Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)		

Are you currently covered by:
☐ Medicare ☐ Medicaid

Authorization to release records:
I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Continuity of Care Benefits under.

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor

_____ Date_____

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Physician:
Please fill out and review the entire form before submission to UnitedHealthcare.

SECTION 3 TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION

Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits

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Diagnosis	Expected Length of Treatment
If maternity, expected date of delivery	If maternity, name of hospital planned for delivery
Current active course of Treatment / Comments	
Signature of Physician	Date

SECTION 4	**FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE**
UnitedHealthcare Representative's Name	Continuity of Care: ☐ Approved ☐ Not Approved (please document reason below)
Comments	
☐ UHC ☐ Uniprise	☐ Fully Insured ☐ Self Funded
UnitedHealthcare Representative's Signature	Date: