Bright HealthCare™

Continuity of Care/Transition of Care

Request Form and Instructions

Use this form when:

- You are an existing Bright HealthCare member and your provider is no longer part of the Bright Health participating provider network (Continuity of Care).
- You are a new member in a Bright HealthCare and your current treating provider is not part of the Bright HealthCare participating provider network (Transition of Care).

Steps to Maintain Continuity of Care

1. **Share this form with your provider and ask them to complete in its entirety.** This form should be completed by your provider only if you are receiving ongoing care or are already scheduled for care.

2. Have your provider submit the request form below within:
   - 30 days of your provider no longer being part of the Bright HealthCare network, **OR**
   - 30 days of your Bright HealthCare coverage being effective
   Requests will be considered for up to 90 days after your enrollment.

3. A separate form must be completed for each family member who needs to have care transitioned to another provider.

4. Completed forms will be reviewed within 10 days of receipt. Requests for organ transplants are an exception and will be reviewed within 30 days.

How to return this form to Bright HealthCare

- Have your provider include this form along with the prior authorization request they send to Bright HealthCare.
- **For Providers:** When submitting the Continuity of Care/Transition of Care Request form along with an authorization request, note on the authorization that it is a Continuity of Care Request.
  - **How to Submit Authorizations:** Go to Availity.com or brighthealthcare.com/provider/utilization-management or information on how to submit an authorization.
- **For Members** mail this form to:
  Bright Health
  Attn: Clinical Programs Delivery
  777 NW Blue Parkway
  Suite 3350
  Lee's Summit, MO 64086

Note: If you have a chronic condition and are not in an acute phase of your illness, you may need to select an in-network provider for your health needs. If you need assistance selecting a new provider, please contact Bright HealthCare as listed below. We'll help you find an in-network provider who meets your needs!

- Individual and Family Plans
  - AL, AZ, CO, FL, IL, NC, NE, OK, SC, TN: **855-827-4448**
  - CA, GA, TX, VA, UT: **844-926-4524**
- Small Group Plans: **855-521-9365**
- Medicare Advantage Plans: **844-926-4521**

If you have questions about your eligibility for continued care, please call us at **855-827-4448,** Monday through Friday, 8am-8pm local time.

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Continuity of Care/Transition of Care Request Form

☐ New Bright HealthCare member *(Transition of Care)*

☐ Existing Bright HealthCare member whose provider is no longer in-network *(Continuity of Care - Form to be completed by Out of Network providers as part of a continuity of care request for Bright HealthCare members).*

Member First Name:	**Member Last Name:**	
Member Phone #:	**Member Date of Birth:**	**Member ID#:**
Member Address:	**City:**	
State:	**Zip:**	
Please describe why member needs continued care from current provider:		

Describe Care of Services Needed:	
1. Member with active course of treatment for an acute medical condition or a serious chronic condition. • An **acute medical condition** involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. • A **serious chronic condition** is due to a disease, illness, or other medical problem serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration.	☐ Yes or ☐ No
2. Member is in an active course of treatment for any behavioral health condition.	☐ Yes or ☐ No
3. Member is pregnant (if the pregnancy that has reached the 2nd or 3rd trimester or if it is a high-risk pregnancy).	☐ Yes or ☐ No
4. Member has a newborn child between the ages of birth and 36 months.	☐ Yes or ☐ No
5. Member has a terminal illness (survival of 6 months or less).	☐ Yes or ☐ No
6. Member has a surgery or other procedure authorized by a previous plan that is scheduled to occur within 90 days of the effective date of Bright HealthCare coverage.	☐ Yes or ☐ No

Member Diagnosis:	
Treatment Being Received:	**Treatment Duration:**
Provider Name:	**Provider Phone #:**
Provider NPI:	**Provider Fax #:**

Provider Specialty:		
Provider Address:	**City:**	
State:	**Zip:**	
I hereby authorize the above provider to give Bright HealthCare any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that I am entitled to a copy of this authorization form. I also authorize Bright HealthCare to leave confidential information on my voice mail at the phone number above.		
Signature of Member, Parent or Guardian	**Date (mm/dd/yyyy)**	