Bright HealthCare

Continuity of Care/Transition of Care

Request Form and Instructions

Bright Health can help you maintain continuity of care when:

- You are an existing Bright Health member and your provider is terminated from or leaves the Bright Health network (Continuity of Care).
- You are a new member in a Bright Health Plan and your current treating provider is not part of the Bright Health participating provider network (Transition of Care).

Steps to Maintain Continuity of Care

1. Share this form with your provider and ask him/her to complete in its entirety. This form is to be complete by your provider only if you are receiving ongoing care or are scheduled for care. Ask your provider to include this complete form with the authorization request they submit for the care you need.

2. Have your provider submit request form below within 30 days of your provider terminating the Bright Health network or within 30 days of your Bright Health coverage being effective. Requests will be considered for up to 90 days from enrollment.

3. Have your provider complete a separate form for each family member who needs to have care transitioned to another provider.

4. How to Return this form to Bright Health
   - Have your provider include this form along with the prior authorization request they send to Bright Health. Fax this form and authorization request to: 1-833-903-1067.
   - **For Providers:** When submitting 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**
       - Fax: Forms to submit authorization requests can be found on the Bright Health website at www.brighthealthplan.com.
       - Fax completed authorization to fax number on the form: 1-833-903-1067
   - **For Members** mail this form to:
     Bright Health
     Attn: Clinical Programs Delivery
     777 NW Blue Parkway
     Suite 3350
     Lee's Summit, MO 64086

5. Complete forms will be reviewed within 10 days of receipt with the exception that organ transplant requests will be reviewed within 30 days.

Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, you need to select an in-network provider to meet your ongoing health care needs and should not need to complete this form. If you need assistance selecting a new provider, please contact Bright Health at **855-827-4448**. We'll help you find an in-network provider who meets your needs!

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

Bright HealthCare™

Continuity of Care/Transition of Care Request Form

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

☐ **Existing Bright Health member** whose provider left the Bright network *(Continuity of Care)*

<table>
<tr><td colspan="2">Member First Name:</td><td colspan="2">Member Last Name:</td></tr>
<tr><td>Member Phone #:</td><td colspan="2">Member Date of Birth:</td><td>Member ID#:</td></tr>
<tr><td colspan="3">Member Address:</td><td>City:</td></tr>
<tr><td>State:</td><td colspan="3">Zip:</td></tr>
<tr><td colspan="4">Please describe why member needs continued care from current provider:</td></tr>
<tr><td colspan="3">Describe Care of Services Needed:</td><td></td></tr>
<tr><td colspan="3">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.</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="3">2. Member is in an active course of treatment for any behavioral health condition.</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="3">3. Member is pregnant (high-risk pregnancy or pregnancy that has reached the 2nd or 3rd trimester).</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="3">4. Member has a newborn child between the ages of birth and 36 months.</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="3">5. Member has a terminal illness (survival of 6 months or less).</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="3">6. Member has a surgery or other procedure authorized by previous plan or its delegated provider scheduled to occur within 90 days of the effective date of Bright Health Plan coverage.</td><td>☐ Yes or ☐ No</td></tr>
<tr><td colspan="4">Member Diagnosis:</td></tr>
<tr><td colspan="3">Treatment Being Received:</td><td>Treatment Duration:</td></tr>
<tr><td colspan="3">Provider Name:</td><td>Provider Phone #:</td></tr>
</table>

Bright HealthCare™

Provider NPI:	Provider Fax #:
Provider Specialty:	
Provider Address:	City:
State:	Zip:
I hereby authorize the above provider to give Bright Health 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 Health to leave confidential information on my voice mail at the phone number above.	
Signature of Member, Parent or Guardian	**Date (mm/dd/yyyy)**

Form to be completed by Out of Network providers as part of a continuity of care request for Bright Health members.