Prominence® Health Plan

Plan effective date: _____

CONTINUITY OF CARE REQUEST FORM

This form is for new members with ongoing health care needs. This information will assist us in transitioning your care when you become effective. Please print and complete all sections of this form. Thank you.

GENERAL INFORMATION

Please select one: ☐ New Prominence Member ☐ Existing Prominence Member Whose Provider Is No Longer on Plan

Member Name:			Member Date of Birth (mm/dd/yyyy):
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child	Cell Phone: (include area code):		Home Phone (include area code):
Mailing Address:			
City	State	Zip	Your Email Address:
Employer:	Select your Prominence plan: ☐ HMO ☐ PPO		Primary Care Provider:

Are you covered by any other health insurance, including Medicare? If so, please complete the information below:

Insurance Carrier: _____ Plan Name: _____

Group #:_____ Policy #: _____

MEDICAL INFORMATION

1	**Have you been hospitalized in the past year?**	☐ Yes ☐ No
	If yes, what were you hospitalized for?	
2	**Do you expect to be in the hospital when coverage with PHP begins or in the next 90 days?**	☐ Yes ☐ No
3	**Are you currently being treated for any illness or condition.**	☐ Yes ☐ No
	If yes to above, please list the illness and conditions below, as well as the treating provider(s) for each. Illness or Condition: Treating Provider: 1) _____ 1) _____ 2) _____ 2) _____ 3) _____ 3) _____	
4	**Do you have a surgery scheduled after your effective date of coverage?**	☐ Yes ☐ No
	If yes to above, what type of surgery?	
	If yes to above, when is your surgery scheduled?	
	If yes to above, who is your surgeon?	
	If yes to above, where is your surgery taking place?	
5	**Are you scheduled for high tech imaging (CT, MRI)?**	☐ Yes ☐ No
	If yes to above, what type of imaging?	
	If yes to above, when is your high tech imaging scheduled?	
	If yes to above, who is ordering physician?	
	If yes to above, where is your high tech imaging procedure taking place?	

6	**Are you pregnant?**	☐ Yes	If yes, what is your due date:
	If pregnant, who is your OB doctor?		
	If pregnant, which hospital are you scheduled to deliver at?		
	If pregnant, is your pregnancy considered high risk (e.g., twins, diabetes, age)		☐ Yes ☐ No
7	**Are you currently receiving chemotherapy or radiation oncology therapy?**		☐ Yes ☐ No
	If yes, who is your treating doctor?		
	If yes, where are you receiving chemotherapy or radiation therapy?		
8	**Are you currently receiving dialysis?**		☐ Yes ☐ No
	If yes, what type of dialysis?		
	If yes, where are you receiving dialysis?		
9	**Are you currently a candidate for an organ transplant?**		☐ Yes ☐ No
	If yes, what type of organ?		
	If yes, which facility?		

Please list any questions that you may have for our nurses in regards to your transition of care

NOTE: If you need continuity of care for ongoing general medical outpatient services have your provider fax a request to **888.393.2335**.

If you have ongoing Radiation/Medical Oncology, physical therapy, speech therapy, Chiropractic services, sleep services, or neck, back or joint services, have your provider call **884.224.0495**.

Your providers can call 775.770.9350 to obtain a prior authorization form or visit our website at www.prominencehealthplan.com.

PHARMACY INFORMATION

Prior to your effective date, please make sure you have enough medication refills. Contact your primary care provider if you have any questions about your ongoing medication needs. You should understand your pharmacy benefit for generic versus brand drugs.

10	**If your are currently taking a drug that requires prior authorization (approval from the health plan), do you have any questions about these?**	☐ Yes ☐ No
11	**Would you like a paper copy of the Preferred Drug list?**	☐ Yes ☐ No

For a complete list of the Preferred and Specialty Drugs, please visit www.prominencehealthplan.com

BEHAVIORAL HEALTH INFORMATION

For questions about your behavioral health benefits, please call Prominence Health Plan at **866.500.2741**.

SIGNATURE OF MEMBER (REQUIRED)

I hereby authorize the above provider to give Prominence Health Plan or any affiliated Prominence company any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under Prominence Health Plan. I understand I am entitled to a copy of this authorization form.

Signature of Member, Parent or Guardian	**Date (mm/dd/yyyy)**

Submit this form by fax to: Prominence Health Plan to our secure fax line at 888.393.2335. If you need to contact Customer Services call **866.500.2741**.

Continuity of Care requests will be reviewed within 10 days of receipt. For new Prominence members, review will occur within 10 days of participants' effective date. Review for organ transplant requests may take longer than 10 days.