Continuity of Care Request Form

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This form should accompany a Prior Authorization (PA) request.
You may enclose it with your PA request or submit it via the Secure Provider Portal.

✱ Indicates required field   *Please Check One: ☐ Inpatient Request   ☐ Outpatient Request

Member Information

*Last Name, First	*Member ID	*Date of Birth (MM/DD/YYYY)

Medical Information

*Physician Name (Last, First)	*Provider/Physician NPI
*Name of Facility	*Facility NPI

*Diagnosis Code	*Procedure Code	*Date of Requested Service (MM/DD/YYYY)

Requestor Information

*Name of Individual Submitting Request (Last, First)	*Phone Number	*Fax Number

Clinical Information — **Complete this section and or attach medical records as needed.**

*What is the patient's current medical condition?

*Is it acute, chronic, terminal, pregnancy-related, or post-surgical?

*Is the patient currently undergoing active treatment?

*What type of treatment is being provided (e.g., chemotherapy, dialysis, behavioral therapy)?

*When did the treatment begin, and what is the expected duration?

▶ **Please complete this form and fax it to Ambetter at: 1-866-884-9580**