

# *Continuity of Care*



CIGNA

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# Your CIGNA HealthCare of California Continuity of Care Benefits

Continuity of Care benefits are intended to provide coverage for individuals who meet all of the following criteria:

1. They have one of several specified medical conditions.
2. They require ongoing treatment for a certain period of time.
3. They are receiving services from doctors, other health care professionals, hospitals or other facilities whose contractual relationship with CIGNA is terminating.

If an individual meets all of these criteria, CIGNA will contact the terminated health care professional and attempt to arrange for the provision of covered services. If the health care professional does not agree to CIGNA's contractual terms and conditions, CIGNA may deny or only provide limited Continuity of Care benefits.

## How it Works

- To request Continuity of Care, you must submit a completed Continuity of Care Request Form within 30 days of your health care professional's contract termination date.
- You must already be receiving care for a qualifying medical condition by the terminated health care professional identified on the Continuity of Care Request Form.
- If Continuity of Care benefits are approved, you will receive the in-network level of benefits for treatment of the specific condition for either a specified timeframe or the duration of the condition.
- Approved benefits only apply to the treatment provided or ordered by the doctor identified on the Continuity of Care Request Form for the medical condition specified on the form.
- The availability of Continuity of Care benefits does not mean a treatment is covered, nor does it constitute pre-authorization of medical services to be provided. Benefit determinations and pre-authorizations must still be obtained during the pre-certification and case management process.
- All benefits are subject to the provisions of the plan.
- You will be responsible for the cost of any services rendered by any terminated health care professional unless they are approved by CIGNA for Continuity of Care benefits.

## Medical conditions and other situations that may qualify for Continuity of Care benefits include:

- An **acute condition**, for the length of the acute condition. An "acute condition" is defined as a medical condition that 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, for a period needed to complete a course of treatment and to arrange for a safe transfer to another doctor, as determined by CIGNA in consultation with the enrollee and treating health care professional, consistent with good professional practice. This period shall not exceed 12 months from the health care professional's contract termination date. A "serious chronic condition" is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and:
  - persists without full cure;
  - worsens over an extended period of time; or
  - requires ongoing treatment to maintain remission or prevent deterioration.
- A **pregnancy**, for the length of the pregnancy (three trimesters) and the immediate postpartum period.
- A **terminal illness**, for the length of the terminal illness. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one year or less.
- **Care of a newborn child whose age is between birth and age 36 months**, regardless of whether the child is undergoing an active course of treatment, for a period not to exceed 12 months.
- **Performance of surgery or other procedure that has been authorized by the plan**, as part of a documented course of treatment that is to occur within 180 days of the doctor's contract termination date.

## If I am approved for Continuity of Care benefits for one illness, can I receive in-network benefit payments for a non-related condition?

In-network benefit levels provided as part of Continuity of Care benefits are for the specific illness/condition only and cannot be applied to another illness/condition. You must complete a Continuity of Care Request Form for each unrelated illness/condition no later than 30 days after the health care professional's termination date.

See instructions for completing this form on the reverse side.



# CIGNA HealthCare Continuity of Care Request Form

**\*\*\*ATTENTION: You may not need to complete this form\*\*\***

• **Complete this form only if you are utilizing a non-participating health care professional. Please check your CIGNA provider directory or check the CIGNA HealthCare® website (www.cigna.com) to confirm that your doctor is in the CIGNA HealthCare network.**

- See reverse for instructions to complete this Continuity of Care Request Form.
- Use a separate form for each condition. Photocopies are acceptable. Attach additional information if necessary.

Employer		Policy #		Employee Date of Enrollment in CIGNA HealthCare Benefit Plan(mm/dd/yyyy)	
Employee Name			Employee Social Security #		Work Phone
Home Address	Street	City	State	Zip	Home Phone
Patient's Name		Patient's Social Security #		Patient's Birthdate (mm/dd/yyyy)	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Self

- Is the patient pregnant?  Yes  No
- If yes, when is the due date? \_\_\_\_\_ (mm/dd/yyyy)
- Is the patient currently receiving treatment for an acute condition or trauma?  Yes  No
- Is the patient scheduled for surgery or hospitalization after your effective date with CIGNA?  Yes  No
- Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate for Organ Transplant?  Yes  No
- Is the patient receiving treatment as a result of a recent major surgery?  Yes  No
- Is the patient receiving mental health/substance abuse care?  Yes  No
- Is the patient receiving care for a terminal illness?  Yes  No
- If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Continuity of Care.

10. Please complete the provider information below.

Group Practice Name		
Doctor's Name		Telephone # of Provider
Doctor's Specialty		
Doctor's Address		
Hospital Where Patient's Doctor Practices		Telephone # of Hospital
Hospital Address		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

- Is this patient expected to be in the hospital when or after coverage with CIGNA begins?  Yes  No
- Please list any other continuing care needs that may qualify for Continuity of Care benefits. If these needs are not related to the condition for which you are applying for Continuity of Care benefits, you must complete a separate Continuity of Care Form.

I hereby authorize the above physician to provide CIGNA or any affiliated CIGNA company with any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Benefits under CIGNA. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

