Continuity of Care Coverage Request

Personal & Confidential

This form is a formal request for your Health and Welfare Plan to cover continuing care from an out of network provider or facility (see related Continuity of Care Questions and Answers). The care must be eligible under the federal Consolidated Appropriations Act. If authorized, continuity of care ends 90 days after the member is notified of this right to request continuity of care or the date the member is no longer under care of the provider or facility, whichever is earlier. If the coverage is not authorized (e.g. not continuity of care required by federal law), care by the non-participating provider or facility will not be covered at the in-network rate. Please complete the following sections:

1. **Section 1 (Employer Information)**
2. **Section 2 (Subscriber/Member Information)**
3. **Section 3 (Authorization) Read the authorization, sign and date the form (if patient is age 17 or older, he or she must also sign and date this form).**
4. **Scan and Email the completed form to AmeriBen for review. The email address is coc@ameriben.com. Or mail completed form to: AmeriBen, ATTN: CoC, PO Box 7186, Boise, ID 83707.**

1. Employer Information	Employer's Name (Please Print)	Plan Effective Date (Required)
2. Subscriber/Member Information	Subscriber's Name (Please Print)	Telephone Number
	Subscriber's Address (Please Print)	
	Member's Name (Please Print)	Birthdate (MM/DD/YYYY)
3. Authorization	I am requesting authorization for continuity of care from the out of network provider or facility named below for care which was permitted prior to the provider's or facility's termination from in-network status. If not approved, I understand that the care specified below will not be covered under the same terms and conditions as if the provider or facility were still covered in-network by the plan. In addition, I authorize the provider or facility to send medical information and/or records requested by AmeriBen that are needed to make a coverage determination. I also authorize the provider, facility, AmeriBen, and a provider network or other payer to communicate and disclose information for Continuity of Care treatment, payment, and operations.	
	Patient's Signature (Required if patient is 17 or older)	Date
	Parent's Signature (Required if patient is 16 or younger)	Date
4. Physician/ Facility Information Please provide all specific information to avoid delay in processing this request.	1. Name of Out of Network Treating Provider or Facility (Please Print)	Telephone Number
	Address of Out of Network Treating Provider or Facility (Please print)	
	2. Name of Out of Network Treating Provider or Facility (Please Print)	Telephone Number
	Address of Out of Network Treating Provider or Facility (Please print)	
	3. Name of Out of Network Treating Provider or Facility (Please Print)	Telephone Number
	Address of Out of Network Treating Provider or Facility (Please print)	

Please list care and specific dates of treatment	**Eligible Care (See attached Questions and Answers)**	**Name of Provider or Facility for this care (From list provided above in Physician/Facility Information)**	**Dates of Treatment (current and anticipated)**

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.
California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.
Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Continuity of Care
Questions and Answers

What is Continuity of Care Coverage, as defined in the Consolidated Appropriations Act?

The federal Consolidated Appropriations Act permits patients to continue care from an out-of-network provider or facility that was previously in-network. Health plan and issuers must allow a member to request and decide to continue to have benefits provided under the same terms and conditions as the member would have had under the plan document had the provider or facility not moved to out-of-network status. Under the Consolidated Appropriations Act, the member has the right to request continuity of care for certain conditions (described below). If authorized, continuity of care ends 90 days after the member is notified by the plan of the right to request continuity of care or the date the member is no longer under care of the provider or facility, whichever of these is earlier.

What care is eligible under the Consolidated Appropriations Act?

Please see your plan language for any limitations or interpretation differences

For plan years beginning on or after January 1, 2022, Continuity of Care under the Consolidated Appropriations Acts is permitted for an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

The term 'serious and complex condition' means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

How will I know if a provider or facility is no longer in-network?

A notice is sent to members when a provider or facility that was in-network moves to out-of-network status because the provider or facility contract is terminated. Terminated means the expiration or nonrenewal of the contract but does not include a termination of the contract for failure to meet applicable quality standards or for fraud. If a member is eligible for continuity of care under the Consolidated Appropriations Act, the member needs to request continuity of care be approved.

How does Continuity of Care under the Consolidated Appropriations Act impact provider or facility payment?

The provider or facility must accept the network payment rate, as well as any network terms and conditions for Continuity of Care under the Consolidated Appropriations Act. This means payment will occur under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the plan or coverage had the provider's or facility's status not changed to out-of-network if care is approved. Continuity of Care, if approved according to the Consolidation Appropriations Act requirements continues until the earlier of 90 days after the plan notifies the member of the right to request continuity of care or the date the member is no longer receiving eligible care by that provider or facility. After the 90 days mentioned, the plan is not obligated to pay the in-network rate and the provider or facility is also not obligated to accept it. Accordingly, after this timeframe out-of-network cost-sharing will occur if the member continues to receive care.

AmeriBen