Continuation of Care Form

Anthem UM Services, Inc.

Date: _____

Instructions: 1. Complete Continuation of Care Request form.
2. Send form to the address or appropriate fax number listed at the bottom of this form.

Patient Information _____
Name Date of Birth

Member Information _____
Name ID Number

_____
Address City, State, Zip Code

Telephone: Home: (__ __ __) __ __ __- __ __ __ __ Work: (__ __ __) __ __ __- __ __ __ __

Doctor Information _____
Name Specialty

_____
Address City, State, Zip Code

Telephone: (__ __ __) __ __ __- __ __ __ __

Facility Information _____
Name Specialty

_____
Address City, State, Zip Code

Telephone: (__ __ __) __ __ __- __ __ __ __

Condition Being Treated:

☐ Pregnancy:
Initial Visit Date: _____Due Date: _____

☐ Scheduled Procedures, Surgeries or Tests _____
Date: _____ Location: _____

☐ Post hospital follow-up visits

☐ Other Diagnosis description or Diagnosis code (if available) (Specify) _____

Procedure description or Procedure code (if available) _____

How long is the treatment expected to continue? _____

Additional Comments: _____

_____

PLEASE NOTE: THE SUBMISSION OF THIS FORM DOES NOT GUARANTEE BENEFITS. CONDITION(S) MUST MEET CRITERIA FOR CONTINUATION OF CARE, AND MEMBER'S HEALTH BENEFTT COVERAGE MUST PROVIDE CONTINUATION OF CARE BENEFITS

Medical Management	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: IN0205-A546 220 Virginia Avenue Indianapolis, IN 46204	***FAX numbers*** *based on the state the member resides in.*	IN: 866-959-1395 KY: 800-730-6061 MO: 866-959-1393 OH: 800-266-3504 WI: 866-959-2154	***Transplant Department***	Transplant Department Anthem BC/BS 13550 Triton Park Blvd Mail Stop: KY0304-A670 Louisville, KY 40223 Fax: 866-255-2471