APPLICATION FOR CONTINUITY OF CARE

FLORIDA

Neighborhood Health Partnership (NHP), a
UnitedHealthcare Comapny
Attn: Medical Management
3100 SW 145 Ave Suite 200
Miramar, Fl 33027
Fax#: 1-800-731-2515

Employee/Applicant:

Continuity of care may enable qualifying existing enrollees covered under Neighborhood Health Partnership to receive care for specified medical conditions for a time-limited period from a newly non-contracted physician or facility at the benefit level associated with contracted physicians and facilities. Services other than for pregnancy or transplant are limited to 6 months or completion of treatment whichever is the shorter period. Future care is to be transferred to a network physician or facility. Acceptance of this application is not a guarantee of benefits, payment or clinical coverage determination. Payment of services is based on your benefit plan at the time services are provided.

Disclaimer: HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUATION OF CARE BENEFITS?

- Read & complete section 1 of the application.
- If you answer No to each question in Section 1, you are NOT eligible for Continuity of Care. Please contact the number on the back of your ID card to have a customer care professional help you in finding a doctor in the Neighborhood Health Partnership network.

THE APPLICATION PROCESS

1. Complete part 2 if you answered YES to any of the questions in Section 1.
   - **Proceed to Part 2 only if you answered YES to at least 1 question in Part 1.**
2. Complete part 2 of the application.
   - **Be sure to sign the authorization form to release your medical records.**
3. Have your physician complete section 3 of the application.
   - **If you are receiving care from more than one physician, each one must individually complete section 3.**
4. Mail the completed application along with relevant medical records to the address noted on the top of this application within 30 days of receipt of notification. If you submit this application after this date, you will not be eligible for the Continuity of Care service.

SECTION 1	**TO BE COMPLETED BY APPLICANT**
Are you pregnant?	☐ YES ☐ NO
Are you currently receiving active treatment for a specific condition?	☐ YES ☐ NO
Briefly describe the condition and treatment:	

SECTION 2 — TO BE COMPLETED BY APPLICANT

Employee Name		Employee Identification Number:
Address	City	State/Zip Code
Home Phone Number	Work Phone Number	
Employer Name		Plan Group Number
Patient Name		Patient's Date of Birth
Patient's Relationship to Employee (i.e., spouse, dependent, self)		

Are you currently covered by:
☐ Medicare ☐ Medicaid

Authorization to release records:

I authorize all physicians and other health care professionals or institutions to provide Neighborhood Health Partnership information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient's eligibility for Continuation of Care Benefits under.

Patient's Signature / Parent or Guardian's Signature if Applicant is a Minor

____ Date_______________________________

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Physician:

Please fill out and review the entire form before submission to Neighborhood Health Partnership.

SECTION 3	TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION	
Physician Name	Physician Number	Phone Number
Address	City	State/Zip Code
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Diagnosis	Expected Length of Treatment	
If maternity, expected date of delivery	If maternity, name of hospital planned for delivery	
Current Treatment/Comments:		
Signature of Physician		Date

SECTION 4	FOR INTERNAL USE ONLY BY Neighborhood Health Partnership
Care Coordination Representative's Name:	Continuation of Care: ☐ Approved ☐ Not Approved (please document reason below)
Comments:	

☐ NHP	☐ Fully Insured
Care Coordination Representative's Signature: Date:	