

Anthem UM Services, Inc.

Continuation of Care Form

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 BENEFIT 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
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