



CONTINUITY OF CARE FOR NEW MEMBERS

Dear Pending New Member:

Welcome to Community Health Group! Your coverage with us will be effective soon.

We want your transition to Community Health Group to go as smoothly as possible. We have a complete network of qualified health care providers able to meet your health care needs.

If you have not done so already, you must select a primary care physician from our Directory of Physicians and Health Care Providers. Each eligible family member may select a different primary care physician. If your current provider does not have a contract with us, you will need to select a new one from our Directory of Physicians and Health Care Providers.

For help in selecting a primary care physician or other provider, or if you need a Directory of Physicians and Health Care Providers please call Member Services at 1-888-224-4430.

Special Note for New Members Who Have Been Receiving Care for an Ongoing Condition

If you have been receiving care for an ongoing condition, we request that you complete the accompanying "New Member Request for Care Assistance" and return it to Community Health Group before your effective date of coverage to allow timely consideration of any transitional and coordination of care requirements. The Request form also allows you to ask for coverage for completion of covered services from a provider who had been caring for you prior to your effective date of coverage with Community Health Group but who does not have a contract with us*. If you complete a Request form and are eligible, we will attempt to contract with the provider. However, if we do not agree to terms, we are not obligated to provide for the completion of covered services with the nonparticipating provider.

* If you are not sure whether your existing provider has a contract with Community Health Group, please contact Member Services at 1-888-244-4430. This information is also available in our Directory of Physicians and Health Care Providers. If you need a copy, please call Member Services.

If you have not been receiving care for an ongoing condition or do not wish to request completion of covered services with a provider who does not contract with us, there is no need to complete the New Member Request for Care Assistance.

If you complete a New Member Request for Care Assistance, please fax it to us at 619-425-5720 or mail it to:

740 Bay Boulevard
Chula Vista, CA 91910

Attn: Health Care Services/Continuity of Care

Thank you for choosing Community Health Group!



NEW MEMBER REQUEST FOR CARE ASSISTANCE

PATIENT NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH (MONTH/DAY/YEAR)
SUBSCRIBER NAME		SOCIAL SECURITY NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER ()	PREFERRED TIME TO CALL	
CURRENT HEALTH INSURANCE PLAN	COMMUNITY HEALTH GROUP EFFECTIVE DATE	

CONDITIONS THAT MAY REQUIRE TRANSITION/COORDINATION OF CARE OR COMPLETION OF COVERED SERVICES (PLEASE CHECK ALL THAT APPLY):

- Upcoming scheduled surgery or other procedure. Procedure, location, and date authorized: _____
- Recent hospital admission or discharge with on-going current treatment. Reason: _____
- Pregnancy. Due date: _____
- Receiving immediate post-partum care. Delivery date: _____
- Receiving care for an acute condition (describe): _____
- Receiving care for a serious chronic condition (describe): _____
- Newly enrolled member is a child aged 0 to 36 months (Name of child): _____
- Chemotherapy or radiation therapy
- Dialysis
- Pending transplant or transplant received
- Mental health care or treatment for substance abuse
- Special needs including home health care or equipment. Diagnosis and explanation: _____

- Prescription medication that is NOT on Community Health Group's Formulary. To learn what medications are on our Formulary, call Member Services at 1-888-244-4430. This information is also available on our web site, www.chgsd.com. Click on "Members", then click on "Formularies." Choose the Formulary for your plan.
- Permanently disabled
- Terminally ill
- Condition for which coverage has been approved by California Childrens Services
- Received care from a physician for the above condition(s) during the last three months? **YES** or **NO**

Additional comments: _____

Are you covered by other health insurance in addition to Community Health Group?
YES or **NO**

Community Health Group physician(s) selected (if known):

Primary Care: _____

OB/GYN (if applicable): _____

INTERNAL USE ONLY

Follow-Up call by: _____

Date: _____

Date Letter Sent: _____

Action Taken: _____

- Check here if you object to receiving a call from Community Health Group's Member Services Department regarding assistance on non-medical issues identified on this form.

If you have been receiving care from a provider who does not contract with Community Health Group, you may have a right to complete covered services with that provider after your effective date of coverage with Community Health Group.

Please note that to be eligible to complete covered services with the non-participating provider, you must both: have a condition that qualifies* AND affirmatively request that we arrange for the completion of covered services.

* Here are the conditions that qualify:

You or your covered dependent(s) must fall into one or more of the following categories:

- Have an acute or serious chronic condition, or a terminal illness
- Be pregnant or receiving immediate postpartum care
- Have a child who will be covered who is aged 0 to 36 months at the time coverage becomes effective
- Have received authorization within six months prior to the effective date of coverage for surgery or another procedure as part of a documented course of treatment.

If you are eligible, AND request completion of covered services with the non-participating provider, we will offer contract terms to that provider. If we and the non-participating provider agree to terms, we will let you know, either by telephone or in writing, how to access care. However, if we do not agree to terms, we are not obligated to provide for the completion of covered services with the nonparticipating provider. In that case, we will work to make sure your medically necessary care is not interrupted.

To request completion of covered services from a non-participating provider, for each new member for whom completion of covered services is being requested, you must complete, sign and submit to Community Health Group:

1. The "Request for Completion of Covered Services" statement below, AND,
2. The accompanying Authorization For Use Or Disclosure Of Medical Information form.

REQUEST FOR COMPLETION OF COVERED SERVICES

I believe [I/or Name of Newly Covered Member] am/is eligible for completion of covered services from a provider who does not have a contract with Community Health Group, whom I have identified below. I request that Community Health Group determine my eligibility for completion of covered services, and if I am found eligible, I request that Community Health Group attempt to make arrangements for completion of covered services with the provider. I understand that a representative from Community Health Group may contact me to obtain more information. I also understand that if Community Health Group and the provider do not agree to terms, Community Health Group is not obligated to provide for the completion of covered services

Name, Address, and Phone Number of Provider (if more than one, please attach additional sheet):

Name: _____

Address: _____

Phone: _____

Signed: _____

Date: _____

Print Name: _____

Phone: _____

COMPLETE A SEPARATE REQUEST AND AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION FORM FOR EACH NEW MEMBER FOR WHOM COMPLETION OF COVERED SERVICES IS BEING REQUESTED.

After completing the Care Assistance for New Members Form, fax it to us at 619-425-5720 or mail it to:

740 Bay Boulevard
Chula Vista, CA 91910
Attn: Continuity of Care

For additional information regarding eligibility criteria or a copy of the policy and procedure for requesting continuity of care from a terminated or non-contracting provider, please call Member Services at 888-244-4430 or write to us at 740 Bay Boulevard, Chula Vista, CA 91910.



AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION: This authorization for use or disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 *et seq.*

AUTHORIZATION: I hereby authorize (*name of physician, hospital or health care provider*) _____ to furnish to COMMUNITY HEALTH GROUP medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of (*name of patient*) _____.

USES: COMMUNITY HEALTH GROUP may use the medical records and type of information authorized only for the following purposes: TO DETERMINE ELIGIBILITY FOR COMPLETION OF COVERED SERVICES and any others specified below:
_____.

DURATION: This authorization shall become effective immediately and shall remain in effect until (*date*) _____.

RESTRICTIONS: I understand that COMMUNITY HEALTH GROUP may not further use or disclose the medical records and information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No Initial _____

SIGNATURE:

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/representative/spouse*/financially responsible party*)

If signed by other than patient, indicate relationship: _____

Witness: _____

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.