Humana Request for Continuity of Care Form

Certain medical conditions may qualify you to continue receiving treatment from your physician or hospital and to be covered by Humana at the same in-network level of benefits for a specific period of time. This form is provided as a service to you to assist you in your request for continuity of care. Complete and submit this form within 21 days to initiate a review of your medical condition to determine if you qualify for Continuity of Care.

Examples of situations that might involve continuity of care include (please check any that may apply to you or a family member):

- ☐ Home healthcare services you are currently receiving
- ☐ Durable medical equipment that you are currently using
- ☐ Ongoing active medical treatment, such as chemotherapy, dialysis, hospitalization, etc.
- ☐ Pregnancy

Any of the following chronic medical conditions:

- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Cystic Fibrosis
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Lupus
- ☐ Myasthenia Gravis
- ☐ Hemophilia
- ☐ Dermatomyositis
- ☐ Asthma
- ☐ Kidney Disease

- ☐ Amyotrophic Lateral Sclerosis *(ALS, Amyotrophic Lateral Sclerosis)*
- ☐ Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIPD)
- ☐ Other; Explain: ______________________________

Member ID#:		
Patient Name:		
Subscriber Name:		
Address:		
City:	State:	Zip:
Home Phone: ( )		Work Phone: ( )

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Birthdate (MM/DD/YY):	
Type of Plan (Check one): ☐ HMO ☐ PPO ☐ POS ☐ PFFS	
Physician or hospital that you are requesting continuity of care from:	
Name of Individual Filling out Form:	Phone Number:
Beginning date for requested continuity of care:	
<u>Upon completion, please mail form to:</u> Clinical Intake (CIT), Humana 1100 Employers Blvd. Green Bay, WI 54344	<u>Or fax form to the following:</u> (800) 266-3022

This document is available in alternative formats or languages. Please call the Customer Care number on the back of your ID card.