

## Continuity of Care Request

Effective January 1, 2022, protections apply for continuing care patients who are receiving covered services or items from a treating provider or facility who has experienced a change in network status due to certain terminations of contract. **Does not include termination of contract due to failure to meet applicable quality standards or fraud.**

If a provider or facility ceases to be in-network due to a termination of a contract, and you elect to continue care, your Kern Legacy Health Plan may allow you to continue receiving covered health care services for a specific medical condition with the same benefits, under the same terms and conditions that would have applied had the contract not terminated.

To receive this coverage, you must complete this form signed by you and the health care provider and receive a notification of approval for continuity of care benefits.

### Eligibility

You may be eligible for continuity of care benefits if you meet one or more of the following conditions with respect to a recently terminated provider or facility:

- a) Undergoing treatment from the provider or facility for a serious and complex condition defined as:  
An acute illness serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm;  
Or in the case of a chronic illness or condition, one that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time
- b) Undergoing a course of institutional or inpatient care from the provider or facility
- c) Scheduled to undergo non-elective surgery including the postoperative care from the provider or facility
- d) Pregnant and undergoing pregnancy-related treatment from the provider or facility
- e) Terminally ill and receiving treatment for such illness from the provider or facility

### Duration of Coverage

If approved, continuity of care coverage may last up to 90 days starting on the date the plan notified you of the change in network participation or the date the member no longer requires care with the provider or facility (whichever comes first).

### How do I know if I am eligible for benefits under continuity of care?

1. Read and complete Section 1 of this form.
  - If you answered YES to any question, you may be eligible for Continuity of Care benefits. Move on to step 2.
  - If you answered NO to all the questions, you are not eligible for Continuity of Care benefits.

If you need assistance finding a new in-network provider, completing this form, or have questions about your coverage and benefits, please visit [www.kernlegacyhp.com](http://www.kernlegacyhp.com) or contact Member Services telephone number located on the back of your member ID card.

2. If you answered YES to any question in Section 1, please complete Section 2 and ask your health care provider to complete Section 3 of this form.
3. Mail or fax the completed form to:

Kern County Health and Wellness  
1115 Truxtun Ave, 1<sup>st</sup> Flr, Bakersfield, CA 93301  
Fax: (661) 868-3295

<b>Member Name:</b>		<b>Member ID:</b>		
<b>Section 1 (TO BE COMPLETED BY MEMBER)</b>				
1. Are you at least 3 months pregnant or did you deliver less than 6 weeks ago?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
2. Are you pregnant? If yes, has your physician told you this is a high-risk pregnancy?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
3. Are you currently in process of receiving non-surgical treatment for cancer (radiation or chemotherapy)?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of your last treatment:				
4. Are you currently receiving surgical cancer related treatment?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of the last surgery:				
5. Are you receiving active treatment for Human Immunodeficiency Virus (HIV) or symptomatic Acquired Immunodeficiency Syndrome (AIDS)?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of your last treatment:				
6. Are you receiving active treatment for severe or end-stage kidney disease or dialysis?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of your last treatment:				
7. Have you received a recent bone marrow or organ transplant or are you on the waiting list to obtain an organ?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of your last treatment:				
8. Are you currently receiving inpatient services at a facility?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date of admission:				
Please provide the name of the facility:				
9. Are you currently receiving outpatient or inpatient mental health or substance abuse services by a licensed mental health provider?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date you were last seen:				
Please provide the name of the provider:				
10. Are you currently receiving treatment for a serious or terminal condition, non-elective surgery, or other life-threatening condition not described above?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, please provide the date you were last seen:				
Please provide the name of the provider and description of your condition:				

If you answered YES to any of the questions above, continue to Section 2, as you may be eligible for Continuity of Care benefits under your Kern Legacy Health Plan. Submission of this form is not a guarantee of approval.

<b>Section 2 (TO BE COMPLETED BY MEMBER)</b>			
Member Name		Date of Birth	
Address	City	State	Zip Code
Member ID Number:	Home/Cell Phone	Work Phone	
Member's Relationship to Subscriber (e.g., Spouse, Domestic Partner, Dependent, Self)			

### Authorization to Release Records

I authorize all health care providers to release information to the Kern Legacy Health Plans and/or affiliated third party administrators concerning medical care, advice, treatment, or supplies for the member named above. This information will be used to determine the member's eligibility for continuity of care benefits under the Kern Legacy Health Plans.

<b>Member Signature</b>	
Member's Signature/Parent or Guardian's Signature of Applicant is a Minor	Date

<b>SECTION 3 (TO BE COMPLETED BY THE HEALTH CARE PROVIDER CURRENTLY TREATING CONDITION)</b>			
This Section of the form should only be reviewed and completed by your provider if you answered YES to one of the questions in Section 1. If you answered NO to all of the questions in Section 1, you are not eligible for continuity of care coverage and your provider does not need to complete this form.			
Provider Name		Provider NPI	
Phone Number	Fax Number	Provider TIN	
Address	City	State	Zip Code
Date of Last Visit	Date of Next Scheduled Appointment	Frequency of Visits	
Diagnosis		Expected Length of Treatment	
If Pregnancy Related, Expected Date of Delivery		Facility Name	
Current and Planned Treatment/Comments			

### By signing this form,

You, the Provider, agree to abide by the regulations set forth by the No Surprise Act requiring you to accept payment from the Plan (and cost sharing from the member) for items and services as payment in full and continue to adhere to all policies, procedures, and quality standards imposed by the Plan for the member as if the contract termination had not occurred. Submission of this form does not guarantee payment or approval for services provided. Notification of approval/denial under continuity of care benefits will be sent to the member and provider upon determination.

<b>Member Signature</b>	
Member's Signature/Parent or Guardian's Signature of Applicant is a Minor	Date