

University of Texas System Medical Foundation Freedom of Choice Plan Continuity of Care Form

Continuity of care will be issued under special circumstances to allow members to continue treatment with a non-plan provider(s) for a period of time following the date of enrollment. Please complete this form if you or one of your dependents is currently being treated by a non-plan provider. One form must be submitted for each provider. The following is a list of services that may or may NOT be considered for continuity of care.

- Unstable or serious medical problems that require a **limited course of treatment of follow-up care**, such as those listed below, may be eligible for continuity of care. Such medical situations are:
 - pregnancy (third trimester) or high risk
 - recent heart attack
 - newly diagnosed cancer
 - other ongoing acute care
- Children with special needs that require treatments to maintain level of function will be reviewed on a case by case basis
- Examples of chronic medical conditions which are **NOT** typically eligible for continuity of care include:
 - arthritis
 - hypertension
 - diabetes
 - asthma and allergies
- If the treating physician is in the Freedom of Choice network, do **NOT** complete this form. Contact your Primary Care.
- If you have any questions about continuity care or need help completing this form, please call the Memorial Hermann Health Network Providers Medical Management Department at: (713) 448-6588 or (888) 738-8778.

EMPLOYEE/SUBSCRIBER INFORMATION

Employee's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Work Telephone Number: _____

Social Security Number: _____ Effective Date of Coverage: _____

Facility Name: _____

(campus where you are employed)

CONTINUITY OF CARE INFORMATION

Patient Information

Patient's Name: _____ Social Security Number: _____

Relationship to Employee: _____ Primary Care Physician's Name: _____

Condition being treated: _____

How long has the doctor been treating the patient for the current condition? _____ years _____ months

How long is the treatment expected to continue? _____ years _____ months

What is the nature of the treatment? _____

Was the patient hospitalized recently for this condition? Yes No Admission Date: _____

Did the patient have surgery? Yes No What Type? _____ When? _____

If pregnancy-related, list initial visit date: _____ LMP: _____ Estimated Delivery Date: _____

Non-Contracted Provider Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Specialty: _____

Hospital of facility where surgery, treatment, or delivery is scheduled or currently being provided:

Telephone number of hospital or facility: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize _____

Providers Name

to release to Memorial Hermann HealthNet Providers Medical Management Department all information relating to past, present, and future health care examinations, conditions, and treatments for: _____

Brief Description of Medical Condition

This information is to be determined if services for the above provider for the stated condition may be covered on or after the effective date by Memorial Hermann Health Network Providers Medical Management Department.

I understand that continuity of care is subject to contractual limitations and exclusions set forth in the subscriber contract. I also understand that Memorial Hermann HealthNet Providers does not extend the contractual benefits in any way except to provide coverage for the non-plan provider for a temporary time period.

Patient's Signature: _____ Date: _____

Employee's/Legal Guardian's Signature: _____ Date: _____

*If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of medical information.

FOR OFFICE USE ONLY

Approved	Denied	Explanations/limitations

Medical Director/Designee Date

TO PATIENT/EMPLOYEE: Please complete this form and return it to the following address before your effective date of coverage under the Freedom of Choice Plan.

**Memorial Hermann Health Network Providers
Medical Care Management Department
9301 Southwest Frwy, 5th Floor
Houston, Texas 77074
Fax to: (713) 448-6381**