

### CONTINUED CARE REQUEST

Under certain circumstances, members may continue to receive care from a provider or hospital that is not a part of Great-West Healthcare's provider network. For specific conditions and treatments, new members can continue to receive care from a non-network provider or hospital from which they were receiving care at the time of enrollment, and existing members can continue to receive care from non-network providers or hospitals from which they were receiving care at the time the provider or hospital leaves the Great-West healthcare network. The goal is to provide continuity of care by allowing patients to retain their current provider(s) or hospital(s) for a limited time until the care is completed or transferred as appropriate to a Great-West Healthcare provider or hospital. The plan's Medical Director will review your request for continued care. If your request is approved, benefits for the qualifying condition are payable by Great-West Healthcare. If your request is not approved, this determination should NOT be interpreted as a denial of medical necessity. Additionally, if you are a new member, this determination does not affect the selection of Great-West Healthcare as your carrier for health care coverage. It simply determines whether Great-West Healthcare will be financially responsible for your continued care with a provider or hospital that is not in the network. If you choose to seek continued care with a non-network provider or hospital, the non-network provider or hospital will need to agree to the network and plan requirements for continued care.

Requests that involve the following conditions will be considered:

- An acute condition for the duration of the condition.
- A serious chronic condition for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, not to exceed 12 months.
- A pregnancy through the course of the pregnancy and during the immediate postpartum period.
- A terminal illness for the duration of the terminal illness.
- Care of a newborn child whose age is between birth and 36 months, for a period not to exceed 12 months.
- Performance of surgery or other procedure that is considered a covered benefit, is considered medically necessary, and has been authorized by Great-West Healthcare or your previous plan, as part of a documented course of treatment that is to occur within 180 days.

In all cases, the Great-West Healthcare Medical Director makes the final determination.

If you feel this applies to you, complete the information on the next page and mail this form within 30 days of your enrollment in the plan or within 30 days of your provider's or hospital's termination. We will evaluate your request and make a determination within 5 business days of receipt of the information needed to render a decision. We may contact you for more information.

Mail completed form to:

**Great-West Healthcare of California**  
**Regional Care Director**  
**655 North Central Avenue, 19<sup>th</sup> Floor**  
**Glendale, CA 91203**

Great-West Healthcare insurance coverage and administrative services to self-funded plans is provided, outside of NY, by Great-West Life & Annuity Insurance Company and Alta Health & Life Insurance Company as well as to certain group business of New England Life Insurance Company and Metropolitan Life Insurance Company. In New York, Great-West Healthcare insurance coverage and administrative services to self-funded plans is provided by First Great-West Life & Annuity Insurance Company. HMO coverage is provided by Great-West Healthcare of California, Inc.

**Request for Continuity of Care Coverage**

Employer Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
(if available)

Prior Plan Name: \_\_\_\_\_ Prior Plan # \_\_\_\_\_ Prior ID# \_\_\_\_\_  
(Applies to new enrollees)

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_ Day Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Patient Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Selected PCP \_\_\_\_\_ Medical Group \_\_\_\_\_

Medical Condition \_\_\_\_\_

Explanation of the reason(s) member requests continued care with the provider or acute care hospital:

\_\_\_\_\_  
\_\_\_\_\_

Name and telephone numbers of all physicians involved in the treatment:

**Physician**

**Telephone #**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Hospital Name**

**Hospital Address**

\_\_\_\_\_

\_\_\_\_\_

I hereby authorize any insurance company, health care provider, or other entity having knowledge of the person identified on this form to give Great-West Healthcare or its designated agent(s) any and all records pertaining to that person's medical, mental/nervous, and/or substance abuse history for purposes of review, investigation, or evaluation by Great-West Healthcare's administrative staff. This authorization is valid for six months from the date that I sign it. I, or my authorized representative, is entitled to a copy of this signed authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date