

Please complete this form if you are currently receiving medical care from a physician / facility that is no longer participating in your provider network and you would like assistance in continuation of care. Continuity of Care, for covered services, may be available for up to 90 days.

Member Name: _____ ID # / SSN: _____

Patient Name: _____ Patient Date of Birth: _____

Relationship to Member: _____

Patient Address (Street, City, ST, Zip): _____

Patient Phone: (home) _____ (cell) _____

MEDICAL INFORMATION

What is the Health Condition, Diagnosis, or Treatment Plan for which the Patient is seeking Continuity of Care Benefits?

Is Patient Receiving Care For Pregnancy? YES ☐ NO ☐ If Yes, due date? _____

Is There a Surgery Scheduled or Recently Done? YES ☐ NO ☐ If Yes, date of surgery? _____

Is The Patient on a Transplant List? YES ☐ NO ☐

Is The Patient Receiving Cancer Treatment? YES ☐ NO ☐

Is There an Upcoming Appointment? YES ☐ NO ☐ If Yes, please indicate date of next appointment? _____

PROVIDER INFORMATION: Physician / Facility Name: _____

Physician / Facility Address (Street, City, ST, Zip): _____

Physician / Facility Phone Number: _____ Date of Last Visit: _____

Your case will be reviewed by a Utilization Management Nurse who also may contact you or your provider to obtain medical records for clinical review.

Signed: (Patient or Guardian) _____ Date: _____

Mail Completed Form To:
LINECO, 825 Parkview Blvd, Lombard, IL 60148
Attn: Clinical Review Team

OR

FAX To: 630-906-7598,
Attn: Clinical Review Team

