Continuity of Care

Assistance Request Form

We at Health Net understand that you may be obtaining care from a provider who is not contracted with Health Net. If you feel you have a special situation and your care cannot be transferred to a Health Net network provider on the date of change in your plan, or your new enrollment date with Health Net, you may request that Health Net review your special situation. Under certain circumstances, you may be entitled to continuation of care with this noncontracted provider.

To request such a review, please provide the information below as completely and accurately as possible to avoid delay in processing your request. You or your authorized representative may complete the form. If possible, please complete Section 1 below, then provide this form to your provider to complete Section 2 to assist us in processing your request for continuation of care.

The Continuity of Care Department may contact you at the number provided below for additional information or to resolve your request. Thank you for your prompt attention to this matter. Please note that filling out the Continuity of Care Assistance Request Form does not guarantee requested services will be covered. Each case is reviewed with guidelines and criteria in place.

Section 1 – Continuity of Care Assistance Request Form

Member's name:	Subscriber's name:
Subscriber's ID #:	Member's date of birth:
Please check one: ☐ HMO ☐ POS ☐ PPO ☐ EPO ☐ HSP	
Member's address:	
Member's telephone # (work):	Member's telephone # (home):
Preferred # to call from 8:00 a.m. to 5:00 p.m.:	
Current provider information	
Medical group/insurance company:	Phone #:
Primary care physician:	Phone #:
Current diagnosis/condition description:	
Current treatment(s):	
New provider information: (If you have chosen/been assigned a Health Net network provider)	
Medical group:	Phone #:
Primary care physician:	Phone #:

Reason(s) for requesting continuity of care assistance

My medical need(s) include (Please check all that apply.)

☐ 2nd and 3rd trimester pregnancy and immediate postpartum	☐ Outpatient behavioral services
☐ Acute condition	☐ Serious chronic condition
	☐ Terminal illness

Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Date of scheduled appointment:	Authorization # if available:
Authorized by:	