MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS®

Request for Continuity of Care

FOR MPIHP INTERNAL USE ONLY:

Participant Services Representative Name and Ext. _____

Health Plan Effective Date: _____

Participants should keep a copy for their records and send the completed form as soon as possible, but no later than January 31, 2017, to:

By Mail:
Motion Picture Industry Health Plan
Attn: MPHP - Continuity of Care
P.O. Box 1990
Studio City, CA 91614-0990

By Fax: 818-285-7500 Attn: MPI Continuity of Care

Or call the Motion Picture Industry Health Plan's ("MPIHP") Participant Services Center at 888-369-2007 (opt. 2, to speak with a representative) if you have any questions or concerns regarding this request form.

1. Participant Identification

Participant Name: _____ Participant SSN: _____

Date of Birth: _____/_____/_____

Street Address: _____ City: _____

State, ZIP Code: _____ Home Phone: _____

2. Patient's Continuity of Care Information (1 patient per form please)

Patient Name: _____ Date of Birth: _____/_____/_____

Relationship to Participant: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child

Home Phone: _____

3. Patient's Medical Information (to be completed by provider)

Current Treating Physician requesting Continuity of Care:

Name: _____ Phone: _____

Address: _____

Treating Physician Specialty: _____

NOTE: MPIHP may request medical information in order to evaluate this continuing care request. The determination for your Continuity of Care request will be made once the information has been received and reviewed.