Continuation *of* Care

Request Form

Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)

Form must be fully completed to avoid a processing delay. Please print.

				Date:
Patient's name (last, first, MI):	Patient's phone: ( ) Best time to call:	Date of birth:	HN member ID number:	Gender: ☐ M ☐ F
Patient's address:				
Health Net primary care physician and associated medical group:			Other contact information:	

You may be able to keep seeing your non-Health Net doctor for certain medical conditions. We will review your request based on your coverage for Continuation of Care benefits.

Current attending physician/provider name:		
Physician/provider address:	City:	ZIP code:
Next scheduled appointment date:	Reason for appointment:	
Health Net participating physician: ☐ Yes ☐ No	Specialist with Health Net: ☐ Yes ☐ No	
Is patient pregnant? ☐ Yes ☐ No If "Yes," expected date of delivery:		
Additional services (dialysis, home health care, medical equipment, etc. Please describe below.): ☐ Yes ☐ No		

Please tell us why you want help with your current medical care. Write down the type of services you are asking for.

Details:____

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Other special needs or comments: ____

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(continued)

Ask your doctor to fill in his or her details on this form. Complete the form and return it using the enclosed envelope. You can also fax it to Public Program Coordinator at **1-866-922-0783**.

Cal MediConnect Programs • Coordination of Care Unit • PO Box 9103 • Van Nuys, CA 91409-9103

If you have any questions, please call Member Services at **1-855-464-3571** in Los Angeles County or **1-855-464-3572** in San Diego County **(TTY users call 711)**. A live person is here to talk with you Monday through Friday, 8:00 a.m. to 8:00 p.m. You can leave a voicemail Saturday, Sunday and federal holidays, 8:00 a.m. to 8:00 p.m. We will return your call the following business day. The call is free.

For more information, visit **www.healthnet.com/calmediconnect**.

Member signature or name of the Health Net Member Service Representative taking the request:	Date:

To be filled out by Health Net or subcontracting health plan for Continuation of Care requests only.

☐ DHCS claims file reviewed to verify claims were paid under the Cal MediConnect program for the requested provider.

☐ In the absence of DHCS claims data, requested provider was contacted to obtain patient's visit history (see attached).

Diagnosis:____

ICD code:____________________ Length of treatment:____________________

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