UnitedHealthcare®

Continuity of Care

What is Continuity of Care?

Continuity of Care (COC) for newly enrolled Members is a health plan process that, under certain circumstances, provides Members with continued care with a former, Non-Participating Provider, including general acute Hospitals, while transitioning to a Participating Provider. It also applies to existing Members impacted by a Participating Provider (practitioners and general acute care Hospitals) termination. The COC process acts like a "bridge of coverage" as you transition from your old plan to your new UnitedHealthcare of California (UnitedHealthcare) plan or from a terminated Provider to a UnitedHealthcare Participating Provider. To qualify, you must have been receiving Covered Services from the (i) Non-Participating Provider at the time of the change in health plans or (ii) from the terminated Provider on the Effective Date of contract termination, for one of the following conditions:

1. **An Acute Condition** is a medical condition, including medical and mental health[1], that involves a sudden onset of symptoms due to an illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** is a medical condition due to disease, illness, or other medical or mental health problem[2] or medical or mental health[2] disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a UnitedHealthcare Medical Director in consultation with the Member, (i) the terminated Provider or (ii) the Non-Participating Provider and, as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's termination date or twelve (12) months from the Effective Date of coverage for a newly enrolled Member.
3. **A pregnancy** diagnosed and documented by (i) the terminated Provider prior to termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's Effective Date of coverage with UnitedHealthcare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, which may exceed twelve (12) months, provided that the prognosis of death was made by the: (i) terminated Provider prior to the agreement termination date or (ii) Non-Participating Provider prior to the newly enrolled Member's Effective Date of coverage with UnitedHealthcare.
5. **The care of a newborn:** Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement termination date, or (ii) the newly enrolled Member's Effective Date of coverage with UnitedHealthcare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure:** Performance of a Surgery or Other Procedure that has been authorized by UnitedHealthcare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) terminating Provider to occur within 180 calendar days of the agreement's termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's Effective Date of coverage with UnitedHealthcare.

Covered Services for the Continuity of Care condition under treatment by the Non-Participating or terminated Provider will be considered complete when:

i. the Member's Continuity of Care condition under treatment is medically stable; and

ii. there are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a UnitedHealthcare Medical Director in consultation with the Member, the treating non-participating or terminated Provider and as applicable, the Member's assigned Participating Provider.

In addition, a formal determination must be made by UnitedHealthcare or your assigned medical group/IPA that

1 Except pursuant to the CA Health and Safety Code §1374.72, in-patient coverage for mental health is not a covered benefit under UnitedHealthcare of California.

2 U.S. Behavioral Health Plan, California will coordinate Continuity of Care for members whose employer has purchased supplemental mental health benefits and for members requesting continued care with a terminated or Non-Participating Provider for "serious mental illnesses" and "serious emotional disturbances of a child" as defined in CA Health and Safety Code §1374.72.

- New Members do not qualify for Continuity of Care if the Member has been offered an out-of-network option, or had the option to continue with a Health Plan or Provider and voluntarily chose to change Health Plans.

a change in Providers on your Effective Date of enrollment or the Provider termination date would have a negative effect on your health.

Continuity of Care also applies to (i) new UnitedHealthcare Members who are receiving mental health care services from a non-participating mental health Provider on their Effective Date of enrollment with UnitedHealthcare or (ii) to existing Members who are receiving mental health care services from a terminated mental health Provider, on the Effective Date of contract termination. A mental health Provider is any of the following: psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker.

Members eligible for continuity of mental health care services may continue to receive Mental Health Services from the treating non-participating or terminated mental health Provider for a reasonable period of time to safely transition care to a UnitedHealthcare Participating mental health Provider. Please refer to the Medical Benefits and the "Exclusions and Limitations" sections of your UnitedHealthcare of California *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form*.

Who authorizes Continuity of Care?

If you or a member of your family is currently receiving medical care for one of the conditions as specified above that was authorized by your previous health plan, or the terminated Provider, you have the right to request a clinical Continuity of Care review by using the appropriate form, as attached *(Request for Continuity of Care Benefits* ***or*** *Request for Mental Health Continuity of Care Benefits).*

COC with your treating Provider may be authorized in those cases which a change in Provider could adversely affect you or your Dependent's clinical care. Member preference for a particular Physician or Provider will not qualify you for COC benefits. If you do not receive Preauthorization by UnitedHealthcare or by your chosen medical group/IPA, payment for services rendered by the non-participating or terminated Provider will be your responsibility.

If you think you or a member of your family qualifies for COC, complete the appropriate COC request form and forward it to UnitedHealthcare as soon as possible, but not later than thirty (30) calendar days of: (i) your Effective Date of enrollment with UnitedHealthcare or (ii) your treating Provider's Effective Date of termination. Exceptions to the thirty (30) calendar day time frame will be considered for good cause.

Upon receipt of the completed form, UnitedHealthcare's Health Services department will complete a clinical COC review. The decision will be made and communicated to you in a timely manner appropriate for the nature of your condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of UnitedHealthcare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will also be sent to you by United States mail, within two (2) business days of making the decision. If your request for continued care with your treating Provider is denied, the written notice will include the reason(s) for the determination and information about how you can appeal the decision. If you have any questions about this process, please call the UnitedHealthcare Customer Service department.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

CALIFORNIA

UnitedHealthcare®

Request for Continuity of Care Benefits

Subscriber and Plan Information

Subscriber Name	ID# (if known)	Social Security #	
Address	City	State	ZIP
Type of Current UnitedHealthcare Plan ☐ HMO ☐ POS ☐ Other:	Effective Date of Current UnitedHealthcare Plan (if applicable):	Home Phone	Work Phone
Employer Name	Employer Group #	Prior Insurance (if applicable)	Prior Medical Group/IPA or Terminated Provider (as applicable)

Patient, Physician and Treatment Information

Patient Name	Relation to Subscriber	Date of Birth	Phone
Address (if different from Subscriber)			
Present Treating Physician or Provider	Treating Physician's/Provider's Phone	Treating Physician's Specialty	
Treating Physician's/Provider's Address			
How long has Physician/Provider been treating Patient?	Expected Date of Delivery (if applicable)	Hospital (if applicable)	
New Primary Care Physician or Medical Group/IPA (selected from UnitedHealthcare Provider List)			
Nature of Illness/Comments (Describe condition being treated. Include diagnosis, expected treatment duration and dates of surgery if scheduled.) Please use a separate sheet for additional comments.			

- **Explanation:** This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. Please note that if you are requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you will be provided with separate authorization forms which have been adopted to comply with the heightened protections for these treatment records afforded by federal and state laws. If you are not requesting Continuity of Care Benefits for treatment relating to mental health or substance abuse, you should complete this form and return it to UnitedHealthcare, Mail Stop: CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department. **Fax transmissions may be directed to UnitedHealthcare, Continuity of Care Department, 1-888-361-0514.**
- **Authorization:** I hereby authorize (name of Physician, Hospital or health care Provider) _____ to furnish to UnitedHealthcare of California medical records and information pertaining to medical history, medical condition, services rendered or treatment of (name of patient) _____
- **Limitations:** This authorization does not apply to the release of mental health and/or substance abuse records.
- **Uses:** This information will be used solely by UnitedHealthcare of California in order to evaluate the request for Continuity of Care Benefits.
- **Duration:** This authorization shall become effective immediately and shall remain in effect until (date)_____, _____.
- **Restrictions:** I understand that UnitedHealthcare of California may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- **Additional Copy:** I further understand that I have a right to receive a copy of this authorization upon my request. **Copy requested:** ☐ Yes ☐ No **Initial:** _____

Print Name of Patient	Date	Time ☐ A.M. ☐ P.M.
Patient's Signature (if patient is a minor or incompetent, parent's signature or signature of legal representative)		

If you need a mental health COC request form, or have any questions regarding your COC benefits, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 and the hearing- and speech-impaired may call 711 (TTY).

Fax this form to 1-888-361-0514 or fold and mail.

CALIFORNIA

UnitedHealthcare

Request for Mental Health Continuity of Care Benefits

Please complete the entire form.

Subscriber and Plan Information

Subscriber Name	ID# (if known)	Social Security #	
Address	City	State	ZIP
Type of Current UnitedHealthcare Plan ☐ HMO ☐ POS ☐ Other:	Effective Date of Current UnitedHealthcare Plan (if applicable):	Home Phone	Work Phone
Employer Name	Employer Group #	Prior Insurance (if applicable)	Prior Medical Group/IPA or Terminated Provider (as applicable)

Patient, Physician and Treatment Information

Patient Name	Relation to Subscriber	Date of Birth	Phone
Address (if different from Subscriber)		Present Treating Mental Health Provider	
Treating Provider's Phone	Treating Provider's Address	How long has Physician/ Provider been treating Patient?	
Hospital (if applicable)	New Primary Care Physician or Medical Group/IPA (selected from UnitedHealthcare Provider List)		
Nature of Illness/Comments (Describe condition being treated. Include diagnosis and expected treatment duration) Please use a separate sheet for additional comments.			

- **Explanation:** This authorization for use if you are requesting Continuity of Care Benefits for treatment relating to mental health. The release under the Lanterman-Petris-Short Act should be completed by your health care provider if you received mental health treatment in an institutional setting, as opposed to psychiatric or counseling services provided by a private physician. See further explanation below. You should complete this form and return it to UnitedHealthcare, CA124-0181, P.O. Box 30968, Salt Lake City, UT 84130-0968, Attn: Continuity of Care Department. **Fax transmissions may be directed to UnitedHealthcare, Continuity of Care Department, 1-888-361-0514.**
- **Authorization:** I, (name of patient)_____hereby authorize (name of responsible individual who has authorization to release information specified, e.g., physician or other licensee in charge of the patient, or administrator of program) _____ to disclose information and records obtained in the course of my diagnosis and treatment for a mental health related condition to UnitedHealthcare.
- **Limitations on Disclosure:** This disclosure authorized herein shall be limited to a one-time disclosure only and shall be limited to the following types of information: medical records and information pertaining to medical history, medical condition, services rendered, or treatment of (name of patient) _____ . Use the following space to indicate any limitations on the information which can be released. _____
- **Restrictions on Use of Information:** The information and records authorized for disclosure herein are to be used solely by UnitedHealthcare to evaluate my request for Continuity of Care Benefits. A separate authorization must be obtained for any separate use or further disclosure of this information by UnitedHealthcare, unless such use or disclosure is specifically required or permitted by law.
- **Copy of Authorization Form:** I understand that a copy of this authorization form should be provided to me by the individual who has been authorized to release the information specified herein. **Initial:** _____

Print Name of Patient	Date	Time ☐ A.M. ☐ P.M.
Patient's Signature (if patient is a minor or incapable of consenting to the treatment rendered or if patient otherwise lacks capacity to consent, parent's signature or signature of legal representative)		

Release Under Lanterman-Petris-Short Act

- **Explanation:** The following section should be completed by your health care provider if you received mental health treatment in an institutional setting, as opposed to psychiatric or counseling services provided by a private physician. Treatment in an institutional setting includes the following: voluntary treatment in a private institution, hospital, clinic or sanitarium, which includes a department or ward for the care and treatment of persons who are mentally disordered; voluntary treatment in a state hospital or county psychiatric hospital; or involuntary treatment of any kind.

The undersigned, the physician, licensed psychologist, or social worker with a master's degree in social work, who is in charge of the patient, hereby ☐ approves ☐ disapproves the release of information and records to the party specified about. If disclosure is disapproved, give reasons below. Also note below any restrictions on the release of records. _____

Date	Signature (physician/psychologist/social worker)	Degree

If you have any questions regarding your COC benefits, please contact UnitedHealthcare's Customer Service department at 1-800-624-8822 and the hearing- and speech-impaired may call 711 (TTY).

Fax this form to 1-888-361-0514 or fold and mail.