



## Continuity of Care Request

Use this form to tell ADVANTAGE about your current authorized services, specialty pharmacy, and acute treatment

If you have a complex, chronic and/or acute medical conditions, ADVANTAGE will assist you in coordinating the most appropriate and medically necessary care needed, based on your condition. In order to maximize the benefits under your ADVANTAGE plan, all care must be provided by an "in-network" provider contracted with your PCP's network. An exception to this policy MAY be a member who, on the effective date of coverage, is in **active treatment for an acute phase of illness or episode with a non-participating provider**. In this case, care MAY be authorized to continue with the non-participating physician if medically appropriate (as determined by the ADVANTAGE Network's medical review). However, it is very important to recognize that some treatments may safely be immediately transitioned and provided by an in-network provider on the effective date of coverage. Your PCP's contracted network will assist in coordination of care.

If you believe you have a medical care need that meets the above criteria, **please fill out the information below and fax it to 317-573-2841**. The information will be reviewed and Utilization Review Nurse will contact you with the decision within two (2) business days of receiving all of the necessary clinical information. If you have any questions, please contact an **ADVANTAGE Medical Affairs Department at 1-866-646-0288**.

### PLEASE PRINT

Employer Location: \_\_\_\_\_ Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last Name, First Name, MI)

Address: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Daytime  
(\_\_\_\_) \_\_\_\_\_ Evenings

Individual requesting continuity of care:  Self  Spouse or Dependent Name: \_\_\_\_\_

Current Attending Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please sign a Release of Information at current provider to facilitate the assessment of your request. Date completed \_\_\_\_\_

Which Primary Care Physician did you select with ADVANTAGE? \_\_\_\_\_

Reason for request:  Current Authorization (please attach authorization letter)  Biopharmaceutical (Specialty) Drug (Drug Name: \_\_\_\_\_)

Undergoing **acute** treatment (Check one:  Unstable condition  Active treatment  Post-op follow-up  3<sup>rd</sup> trimester pregnancy  Repeat high risk procedure)

Current Treating Physician(s), Hospital Affiliations and phone numbers (attach additional page, if necessary):

Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Which ADVANTAGE Network plan did you select? \_\_\_\_\_

Describe current medical condition(s): \_\_\_\_\_ (Please attach additional pages as needed)