CareFirst
Family of health care plans

Continuation of Care

Information and instructions

Welcome to CareFirst

One of your concerns as you seek enrollment in a CareFirst BlueCross BlueShield (CareFirst) plan may be continuation of treatment. CareFirst patients and their covered dependent(s) who recently enroll in DC fully-insured plans may be eligible for the Continuation of Care process.

What is Continuation of Care?

Per the DC Prior Authorization Reform Amendment Act of 2023, CareFirst will honor an approved prior authorization from previous carriers for new enrollees in DC fully insured plans. Approved prior authorization requests will be honored for at least the initial 60 days of an enrollee's coverage under the new health benefits plan. The Continuation of Care process is subject to benefit eligibility.

Who should use this form?

If you or your covered dependent(s) have an approved prior authorization request from your previous carrier, you should complete this form.

Please be sure to submit a separate form for each approved prior authorization request from you or your dependent's previous carrier.

Please complete the Insurance and Patient Information sections on the other side of this form. Also, have the physician complete the Physician Information section. Return the form according to the Instructions section.

Qualified medical professionals in the CareFirst Utilization Management Department will review the request and make a determination following the receipt of all required information. If the services do not qualify for Continuation of Care, you and your provider will also be notified in writing.

PRD1183-1E (11/24)

Continuation of Care Request Form

For patients in a District of Columbia-based, fully insured plan

CareFirst Family of health care plans

INSTRUCTIONS

Mail the completed form and any attachments to: CareFirst BlueCross BlueShield, Pre-Service Review Department, 1501 South Clinton Street, 8th Floor, Mail Stop: CT-08-02, Baltimore, MD 21224

Or fax the completed form and any attachments to: 410-720-3060, Attention: Pre-Service Review

If you have any questions concerning benefits or provider status, contact Member Services. The phone number is listed on the back of your identification card.

Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**.

SECTION 1—INSURANCE INFORMATION

Policy Holder's Name		Date of Birth	Home Phone	
Street Address		City	State	ZIP Code
Group Name		Group #	Effective Date of Coverage	
Member ID #	Check one ◯ HMO ◯ POS ◯ PPO	Date on Notification	Received via ◯ USPS ◯ Email	

SECTION 2—PATIENT INFORMATION

Patient's Name	Patient's Date of Birth

SECTION 3—PROVIDER INFORMATION

Name of Provider Currently Treating Condition		Specialty	Provider TIN/NPI	
Diagnosis/ICD10	Procedure Code(s) (CPT/HCPCS)	Date Treatment Started	Date of Next Treatment/Visit	
Street Address		City	State	ZIP Code
Phone		Fax		

Please provide documentation of approved prior authorization.

SECTION 4—SIGNATURES

I attest that the information submitted with this request is accurate. I understand that Continuation of Care is subject to contractual limitations and exclusions set forth in the member's policy.

If the patient is younger than 18, the Policy Holder must sign this form.

Patient's Signature	Date
Policy Holder's Signature	Date
Provider signature (applicable if transitioning from another carrier)	Date

OFFICE USE ONLY—COC begin and end date