Continuation of Care Request

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SANFORD HEALTH PLAN

Application Instructions

Follow the steps below to find out if you should complete this form.

STEP 1

Make sure that your health care provider is in Sanford Health Plan's network.
You can check this two ways:

1. Look for your provider under **Doctors and Pharmacies** at **align.sanfordhealthplan.com**
2. Call Customer Service toll free at **(888) 278-6485 (TTY: (888) 279-1549)**. Our extended hours are 8 a.m. to 8 p.m. CST, 7 days a week from October through March. Our standard hours are Monday through Friday, 8 a.m. to 5 p.m. CST

Check the box below that applies to you:

☐ Yes, the provider I want to continue seeing is in the Sanford Health Plan network.

STOP STOP! You do not need to fill out this form.

☐ No, the provider I want to continue seeing is NOT in the Sanford Health Plan network.

GO to Step 2.

STEP 2

AND you would like to continue care with this provider because you have one of the medical or behavioral conditions below:

1. A surgery which is already planned
2. Receiving cancer treatments
3. Receiving transplant services
4. Receiving services where it would be deemed harmful to transition at this point of treatment
5. A life threatening mental or physical illness
6. A physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for a least one year, or can be expected to result in death
7. A physician's certification that there is an expected lifetime of 180 days or less
8. Additional services requiring a Continuation of Care request

Check the box below that applies to you:

☐ Yes, I am affected by one of the conditions listed above.

GO to Step 3.

☐ No, I am not affected by one of the conditions listed above.

STOP STOP! Please call (888) 278-6485 (TTY: (888) 279-1549) for continuation of care questions not addressed on this form.

STEP 3

This form must be completed within 90 days of your plan's effective date or within 90 days of your provider terminating with the Sanford Health Plan network.

Return this form via mail or fax to:

Sanford Health Plan
Attn: Continuation of Care
PO Box 91110, Sioux Falls, SD 57109
Fax: (605) 312-8219

Medical records may be requested to fully review your case for a Continuation of Care. You will receive a letter notifying you whether the request is approved.

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☐ New enrollee to Sanford Health Plan ☐ Existing member whose provider terminated from your plan's network

Member's name	Sanford Health Plan member ID	Member's date of enrollment in plan
Home address (including City, State and Zip)		Home/mobile phone
Member's social security # or alternate ID	Member's date of birth	Relationship to member ☐ Self ☐ Authorized Representative

Is the member scheduled for surgery or hospitalization after your effective date with Sanford Health Plan? ☐ Yes ☐ No
Is the member involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? ☐ Yes ☐ No
Is the member receiving transplant services? ☐ Yes ☐ No
Is the member receiving services where it would be deemed harmful to transition at this point of treatment? ☐ Yes ☐ No
Is the member receiving treatment for a life threatening mental or physical illness? ☐ Yes ☐ No
Do you have any cultural needs to be considered during your continuation of care? ☐ Yes ☐ No

If you answered **YES** to any of the above questions, please describe the condition for which the patient requests Continuation of Care in the section below or attach it on a separate piece of paper.

Clinic or group practice name		
Health care provider name and specialty		Health care provider phone #
Health care provider address		
Hospital where health care provider practices		Hospital phone #
Hospital address		
Type of surgery (if applicable)		Date of surgery (if applicable) (mm/dd/yyyy)
Reason for treatment or diagnosis		
Treatment being received and expected duration		
When did this condition begin (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy)	Frequency of visits (if applicable)

I understand that submission of this form does not guarantee authorization or payment for the requested services. I certify and attest that, I am the above-referenced Patient and submit this form on my own behalf (or am such Authorized Represenative and submit this form on the patient's behalf; and to the best of my knowledge, information, and belief, I have provided true and correct responses to all questions). I hereby authorize the above health care provider to give Sanford Health Plan or its affiliates and contracted parties' any and all information and medical records necessary to make an informed decision concerning my request for Continuation of Care. I understand I am entitled to a copy of this authorization form.

Signature of Member or Authorized Representative	Date (mm/dd/yyyy)