mint. Health Plans

Continuity of Care Request

Return to Mint Member Services
info@minthealthplans.com · (435) 754-7860
30 S Main, PO Box 36, Smithfield, UT 84335

This form is used to request continuation or transition of care with a provider who is not participating in the plan's network. Approval is based on the member's clinical circumstances, applicable plan provisions, and applicable law. Submission of this form does not guarantee approval.

Confidential. Send this form directly to Mint. Do not route it through your employer or HR. Medical records are not needed; we will request them from your provider if required.

1 Subscriber Information

SUBSCRIBER NAME | DATE OF BIRTH | MEMBER ID

EMPLOYER / GROUP NAME | PHONE | EMAIL

2 Patient Information

☐ Same as subscriber (skip to Section 3)

PATIENT NAME | DATE OF BIRTH | RELATIONSHIP TO SUBSCRIBER

MEMBER ID (IF DIFFERENT) | PHONE (IF APPROPRIATE) | EMAIL (IF APPROPRIATE)

3 Provider / Facility Information

PROVIDER / FACILITY NAME | TREATING PHYSICIAN NAME

SPECIALTY | NPI (IF KNOWN) | TAX ID (IF KNOWN)

ADDRESS

PHONE | FAX

Has the provider told the patient they are out of network with this plan? ◯ Yes ◯ No ◯ Not sure

4 Type of Ongoing Care Check all that apply

- ☐ Active treatment for a serious or complex condition
- ☐ Pregnancy / maternity care
- ☐ Ongoing physical therapy or rehabilitation
- ☐ Postoperative care
- ☐ Terminal illness / hospice-related care
- ☐ Cancer treatment
- ☐ Behavioral health treatment
- ☐ Scheduled surgery or procedure
- ☐ Inpatient or institutional care
- ☐ Other:

5 Treatment Details

DIAGNOSIS OR GENERAL CONDITION

DATE TREATMENT BEGAN | FREQUENCY OF VISITS | EXPECTED DURATION

NEXT SCHEDULED APPOINTMENT | EST. TREATMENT COMPLETION | PROCEDURE SCHEDULED?

◯ Yes (see §7) ◯ No

6 Reason Continuity of Care Is Requested

Briefly explain why changing providers now could disrupt the patient's care.

OTHER NETWORK OPTIONS

Have you tried to locate an in-network provider for this care? ◯ Yes ◯ No

If yes, was an appointment available within a reasonable timeframe? ◯ Yes ◯ No

IN-NETWORK PROVIDER(S) CONTACTED AND EARLIEST DATE OFFERED

7 Upcoming Appointments / Procedures

APPOINTMENT / PROCEDURE

DATE

FACILITY

PRIOR AUTHORIZATION OBTAINED?

◯ Yes ◯ No ◯ Not sure

ADDITIONAL APPOINTMENT / PROCEDURE (IF ANY)

DATE

8 Authorization to Contact Provider

☐ I authorize Mint Health Plans and its clinical review team to contact the provider(s) listed on this form to obtain the information needed to evaluate this request, including medical records. Information obtained will be used only to review this request and will be protected in accordance with HIPAA.

9 Member Certification and Signature

☐ I certify that the information on this form is accurate and complete to the best of my knowledge.

☐ I understand that submission of this form does not guarantee approval. Any approval is subject to the member's clinical circumstances, applicable plan provisions, and applicable law.

SIGNATURE OF MEMBER OR AUTHORIZED REPRESENTATIVE

DATE

PRINTED NAME

IF REPRESENTATIVE, RELATIONSHIP TO PATIENT

How to submit

Email to info@minthealthplans.com or mail to Mint Health Plans, Attn: Member Services, PO Box 36, Smithfield, UT 84335. Do not send through your employer.

What happens next

Our clinical review team will review your request, contact your provider if more information is needed, and notify you of the decision in writing.