Continuity of Care

Continuity of Care allows Judi Health covered members to continue to access care from a provider whose participating provider agreement has expired or been termed, or who is otherwise now considered out-of-network under your plan. Judi Health currently utilizes the Cigna network. Visit cigna.com to confirm your provider's network status.

How Continuity of Care Works:

Generally, if your provider's network status changes and you qualify for continuity of care by law, you will receive a notice from your plan letting you know the effective date of such change (referred to herein as the "Effective Date") and of your possible right to continuity of care with such provider.

You must already be under current treatment by the identified non-contracted provider or have scheduled a future nonelective procedure with the identified non-contracted provider prior to the Effective Date. Your request will be evaluated based on applicable law and plan benefits.

If your request is approved for the medical condition(s) and/or provider(s) listed in your form(s), you will receive the network level of coverage for treatment specific condition(s) by the health care professional for up to 6 months from the Effective Date.
You must make your request for Continuity of Care within 30 days of the Effective Date or you will not be eligible for Continuity of Care.

The availability of Continuity of Care coverage does not guarantee that a treatment is medically necessary or is covered by your plan benefits. Depending on the actual request, a medical necessity determination and formal prior authorization may still be required for a service to be covered.

Examples of Medical Conditions that may qualify for Continuity of Care include, but are not limited to:

- Pregnant and undergoing a course of treatment for pregnancy
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant
- Recent major surgeries in the acute phase and follow-up period
- Serious acute conditions in active treatment such as heart attacks or strokes
- Other serious chronic conditions that require active treatment

To complete this form:

- Please make sure all fields are completed. Completed forms must be signed by the member who is requesting the Continuity of Care. Only complete this form if your provider is out-of-network with your Judi Health plan.
- You must complete and submit the form within 30 days of the Effective Date.
- A separate form must be completed for each member seeking continued care and for each provider with whom a member is seeking continued care.
- Please resubmit the completed form, along with relevant medical records and information (such as prior authorization approvals from your previous carrier) within the above specified timeframe to Judi Health. Please note that while we implement reasonable safeguards to protect your protected health information (PHI) sent through email, there is some risk your PHI could be read or otherwise accessed while in transit. If you prefer, you may instead mail or fax your information. Completed forms can be sent to:
    - E-mail: inquiries@judihealth.com
    - Fax: 833-FAX-JHLT (329-5458)
    - Mail: Judi Health Attn: Claims Dept 9450 SW Gemini Dr., #87234 Beaverton, OR 97008
- After receiving your request, Judi Health will review and evaluate the information provided. Incomplete forms will be returned to the requestor.

Member Information

☐ New Judi Health Member: ☐ Existing Judi Health member whose care provider terminated	Provider Termination Date:	
Name of Person Being Treated:	ID Number:	Date of Birth (MM/DD/YYYY):
Address:	City:	State/Zip Code:
Home/Cell Number:	Employer Name:	Date of Judi Health Enrollment:
Member's Relationship to Employee: ☐ Self ☐ Spouse ☐ Dependent ☐ Other	Is the member currently covered by another health insurance carrier? ☐ Yes ☐ No If yes, carrier name:	

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Authorization to Release Records

I authorize all physicians and other health care professionals or facilities to provide Judi Health information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for Continuity of Care benefits under the plan.

Member's Signature / Parent or Guardian's Signature if Member is a Minor:	**Date:**

Care Provider Section

Your health care provider should complete the following information.

Name (Treating Physician):	National Provider ID (NPI):	Phone Number:
Address:	City:	State/Zip Code:
Facility Name, NPI, City and State (if applicable):		Facility Phone Number:
Date of Last Visit:	Next Scheduled Visit:	Frequency of Visits:

Diagnoses:	Expected Length of Treatment (Expected Delivery Date if Maternity):
1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

Please select 1 of the descriptions if it applies:

☐ Life Threatening Condition	☐ Acute Condition	☐ Transplant	☐ Inpatient/Confined
☐ Upcoming Surgery	☐ Disabled/Disability	☐ Terminal Illness	☐ Ongoing Treatment

Current Condition and Treatment Plan

Please include a brief description/statement and all relevant CPT codes.

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Providers: If the member is eligible, you agree to provide the covered service, including any follow-up care covered under the member's plan, for the applicable time frame, and follow our policies and procedures. For out-of-network providers seeing new members: If the member is eligible, we will provide coverage at the network benefit level, and payment will be consistent with the member's benefit plan. You agree to accept payment from us along with any cost-share for which the member is responsible under the plan as payment in full for covered services. You will neither seek to recover nor accept any payment in excess of this amount from the member, us, any payer, or anyone acting on their behalf.

Signature of Health Care Professional:	**Date:**