Dear Meritage Member,

As of January 1st, 2021, St. Joseph Health specialist(s) will no longer be a provider for the Meritage Medical Network. **If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period.** The Continuity of Care Department at Meritage Medical Network is dedicated to helping you receive uninterrupted and coordinated care.

To request Continuity of care please fill out the Continuity of Care Assistance Request Form located on pages 2 and 3, return the form by **Fax: 415-883-7287, Mail: 4 Hamilton Landing #100 Novato, CA 94949 or by Email: umdept@meritagemed.com**

Each request for continuity of care assistance is considered based on the plan benefit, applicable state regulations, medical appropriateness, and clinical needs. Upon receipt of the Continuity of Care Assistance Request Form, a nurse care manager will be assigned to review your care needs. You will be notified by telephone and/or mail upon receipt of the completed form.

You May request Continuity of Care:

- If you are in an active course of treatment for an **acute medical condition or a serious chronic condition**. An **acute medical Condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider.
- If you are in an active course of treatment for any behavioral health condition
- If you are pregnant, regardless of trimester
- If you have a terminal illness
- If you have a newborn child between the ages of birth to 36 months. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for Continuity of Care, please follow the instructions below:

1. Complete a separate Continuity of Care Assistance request form for **each** requested provider.

2. Section 2 of the Continuity of Care Assistance Request Form (page 3) is an optional section of the form that may be completed by your provider of services to assist with your request; however, it will not be accepted without the member's completed Continuity of Care Assistance Request Form.

3. Please fax, mail or email all forms to Meritage Continuity of Care Department

Fax: 415-883-7287

Mail: Meritage Continuity of Care Department
4 Hamilton Landing #100
Novato, CA 94949

Email: umdept@meritagemed.com

4. Please contact the Meritage Customer Service **1-415-884-1840 or 1-800-874-0840** if you need assistance completing this form or if you have any questions regarding this process .

Continuity *of* Care *Assistance*

We at Meritage understand that you may be obtaining care from a provider who is not contracted with Meritage. If you feel you have a special situation and your care cannot be transferred to an in-network provider on the date of change in your plan you may request that Meritage review your special situation. Under certain circumstances, you may be entitled to continuation of care with this non-contracted provider.

To request such a review, please provide the information below as completely and accurately as possible to avoid delay in processing your request. You or your authorized representative may complete the form. Please complete Section 1 below, then, if possible, provide this form to your provider to complete Section 2 to assist us in processing your request for continuation of care.

Please note that filling out the Continuity of Care Assistance Request Form does not guarantee requested services will be covered. Each case is reviewed with guidelines and criteria in place.

Section 1 – Continuity of Care Assistance Request Form	
Member's First and Last Name:	Member's date of birth:
Subscriber's ID #:	Subscriber's First and Last Name:
Please check one: ☒ HMO	
Member's address:	
Best phone number(s) to reach you:	
Provider information	
Current medical group/Insurance company: **Meritage Medical Network**	Phone #: **415-884-1840**
Has your medical group been changed recently, if so:	
New medical group:	Phone #:
Reason(s) for requesting continuity of care assistance	
My medical need(s) include (*Please check all that apply.*)	
☐ Scheduled procedure/surgery ☐ Acute condition ☐ Serious chronic condition ☐ Terminal illness	☐ Pregnancy and immediate postpartum ☐ Care of newborn between birth and age 36 months (not to exceed 12 months from the effective date of coverage for a newly covered enrollee) ☐ Specialist office visit
Name of specialist(s):	Phone #:
Diagnosis:	
Current treatment(s):	
Date of upcoming appointment:	
Previous appointment/frequency of the visits:	
Other special needs or comments (*Attach another page for additional information as needed.*)	
_____ _____ _____ _____	

Authorization of information	
Member signature:	Date:
Additional person(s) that you are authorizing Continuity of Care Assistance Department to speak with about this request.	
Name:	
Phone number:	Relationship:
If filled out by other than the member	
Name of requestor:	Relation to member:
Phone #:	Date:

Section 2 – Provider information request (optional)

This section is optional, but if completed it must be submitted with the member's completed Continuity of Care Assistance Request Form. It is not required but will expedite the review of your request.

Patient information *(to be completed by the member)*	
Subscriber First and Last Name:	
Patient (member) First and Last Name:	Patient (member) Date of birth:
Address:	Phone #:
Non-network treating provider name:	Office Phone #:
Please note that your provider may require you to complete an Authorization for Release of Information.	
Provider information *(to be completed by the provider)*	
Your patient has requested that Meritage cover care provided by you for a specific diagnosis and period of time. If you agree to continue to see your patient and accept Meritage's standard rates, please provide the requested information so that we can evaluate your patient's request. If you are not willing to accept Meritag's standard rates, please indicate that below.	
Please check one option: ☐ Agree to continue to see your patient accepting Meritage's standard rates. ☐ Not willing to continue to see your patient. You may skip section below.	
Diagnosis:	ICD code(s):
Expected duration of transition:	
Treatment/Treatment plan:	
Treatment/Surgical date:	For pregnancies, EDD:
CPT code(s):	
Non-network treating provider name (print):	Phone #:
Tax ID #:	
Non-network treating provider signature:	Date:

Please return this completed form and any supporting documentation you believe is appropriate to Continuity of Care Department at:

Fax: 415-883-7287

Mail: Meriage Continuity of Care Department
4 Hamilton Landing #100
Novato, CA 94949

Email: umdept@meritagemed.com