

**Independence Blue Cross  
Request for Continuation of Care**

Member ID Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Group Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Zip Code: \_\_\_\_\_ Home Telephone: (\_\_\_\_) \_\_\_\_\_

**PROVIDER INFORMATION:**

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Specialty: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Condition Being Treated: \_\_\_\_\_

How long has the doctor been treating the patient for this condition?

\_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Visits

How long is the treatment expected to continue? \_\_\_\_\_ Years \_\_\_\_\_ Months

Additional Comments:


**Return this form to the following location:**

**CMC Precertification Department  
1901 Market Street, 31st Floor, Philadelphia, PA 19103**

**FAX: 215-241-2173**