

**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, 30th Floor, Philadelphia, PA 19103**

FAX: 215-241-0257