Continuation of Care Request Form

Care Management and Coordination

Member ID # _____ Effective date of coverage _____

Subscriber name _____

Group # _____ Group name _____

PATIENT INFORMATION:

Patient name _____ Date of birth _____

Street address _____

City _____ State _____

ZIP _____ Home phone # (_____) _____

PROVIDER INFORMATION:

Doctor name _____

Street address _____

City _____ State _____ ZIP _____

Specialty _____ Office phone # (_____) _____

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 _____

_____

_____

Please fax this form to 215-761-0943 or mail it to:

CMC Precertification Department
Continuation of Care
1901 Market Street, 30th Floor
Philadelphia, PA 19103