Minuteman Health Continuity of Care Request Form

Minuteman Health (MHI) allows members a continuation of care period with a provider when a:

- In-Plan Primary Care Provider (PCP) leaves the MHI Network
- In-Plan Specialist* leaves the MHI Network (*for Members that meet the criteria below):
  - Members undergoing active course of treatment for a severe chronic, acute medical condition, or terminal illness
  - Members who are pregnant and in their second or third trimester (through postpartum period)
  - Members in an active course of treatment for a behavioral health condition
- Members have a surgery or other procedure that has been authorized
- Members are currently receiving in-patient hospital services

If any of the above scenarios apply, please fill out the form below to request a case review.

Fax the completed form to: 1-413-747-2612 or Mail the completed form to One Monarch Place, Suite 1500, Springfield, MA 01144

Instructions:

Fill out the information below completely and use N/A if a question is not applicable.
Use one form for each family member.

Subscriber's Name:	
Patient/Member's Name:	
Patient/ Member ID #:	
Relationship to Subscriber:	
Date of Birth:	

Reason for Continuity of Care Request for Consideration:

☐ PCP Request for Continuation of Care with a PCP

Provider Name (Last, First)	
Date of Appointment	
Provider Phone Number	

☐ Request for Continuation of Care with a Specialist

Provider Name (Last, First)	
Specialist Type	
Date of Appointment	
Provider Phone Number	

☐ Request for Hospitalization, Procedure or Surgeries

Provider Name	
Type of Surgery or Procedure	
Date of Surgery or Procedure	
Provider Phone Number	

I hereby authorize the above provider to give Minuteman Health, Inc. any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care. I understand that Minuteman Health, Inc. may share information and discuss my care with my new Primary Care Provider/Medical Group. I further understand that Minuteman Health, Inc. will perform a clinical review of my request for continuity of care and that making this request is not a guarantee of coverage. Further, if my request is denied because my care is not subject to continuity of care, I understand that Minuteman Health will work with me to transition my care to In-Plan Provider. I understand that I am entitled to a copy of this authorization form.

Signature of Patient if 18 or over:	Date:
Signature of Parent or Guardian if Patient is under 18:	Date: