Allegiance
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What is Continuity of Care?

Continuity of care coverage allows you to continue to receive services for specified medical conditions for a defined period of time with health care professionals who have ceased participation in your network(s) starting in 2022 and while you were under their care. You must apply for Continuity of Care during the time you are treating with that provider.

How Continuity of Care Works

~You must already be under treatment for the condition identified on the Continuity of Care request form.
~If Continuity of Care is approved for medical or behavioral conditions, you will receive the in-network level of coverage for treatment of the specific condition by the health care professional for a defined time frame, as determined by the Plan. If your plan includes out-of-network coverage and you choose to continue care out of network beyond the time frame approved by the Plan, you must follow your plan's out-of-network provisions. This includes any pre-certification requirements.
~If approved, Continuity of Care coverage applies only to the treatment of the medical or behavioral condition specified and the health care professional identified on the request form. All other conditions must be cared for by an in-network health care professional for you to receive in-network coverage levels.
~The availability of Continuity of Care coverage does not guarantee that a treatment is medically necessary. Nor does it constitute pre-certification of medical services to be provided. Depending on the actual request, a medical necessity determination and formal pre-certification may still be required for a service to be covered.

Examples of acute medical conditions that may qualify for Continuity of Care include, but are not limited to:

~ Serious and complex conditions.
~ Course of institutional or inpatient care.
~ Scheduled non-elective surgery including post-operative care.
~ Course of treatment for pregnancy.
~ Terminally ill patients.

Examples of conditions that do not qualify for Continuity of Care include, but are not limited to:

~Routine exams, vaccinations and health assessments.
~Stable chronic conditions such as diabetes, arthritis, allergies, asthma, hypertension and glaucoma.
~Acute minor illnesses such as colds, sore throats and ear infections.
~Elective scheduled surgeries such as removal of lesions, bunionectomy, hernia repair and hysterectomy.

What time frame is allowed for transition to a new participating health care professional?

If it is determined by the Plan that immediate transition to a participating health care professional is not recommended or safe for the conditions that qualify, services by the approved non- participating health care professional will be authorized. The approved transition period starts on the date the patient receives notification that their health care professional ceased participation in the applicable network(s) and ends either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider or facility, whichever comes first.

If I am approved for Continuity of Care for one illness, can I receive in-network coverage payments for a non-related condition?

In-network coverage levels provided as part of Continuity of Care are for the specific illness/condition only and cannot be applied to another illness/condition. A Continuity of Care request form would need to be completed for each unrelated illness/ condition no later than 30 days after coverage becomes effective.

Can I apply for Continuity of Care if I am not currently in treatment or seeing a health care professional?

You must already be in treatment for the condition that is noted on the Continuity of Care request form.

How do I apply for Continuity of Care?

Continuity of Care requests must be submitted using this form. After receiving your request, your information is reviewed and evaluated. Once complete, Allegiance will send you a letter informing you whether your request was approved or denied. A denial will include information on appeals.

Health Care Continuity of Care Request Form

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if need.

Please note: this form is to be completed with assistance from your health care provider

Employer	Name of Plan Option	Employee date of Enrollment in Healthcare Plan (mm/dd/yyyy)

Employee Name	Employee SS# or Participant ID	Work Phone

Home Address Street	City State	Zip	Home Phone/Cell Phone

Patient's Name	Patients SS# or Participant ID	Patient's Birth Date (mm/dd/yyyy)	Relationship to Employee Spouse ☐ Dependent ☐ Self ☐

1. Is the patient pregnant? Yes ☐ No ☐ Due Date_____(mm/dd/yyyy)
2. If yes, is your pregnancy considered high risk? e.g., multiple births, gestational diabetes, etc. Yes ☐ No ☐
3. Is the patient currently receiving treatment for an acute condition or trauma? Yes ☐ No ☐
4. Is the patient scheduled for surgery or hospitalization after your effective date? Yes ☐ No ☐
5. Is the patient involved in a course of chemotherapy, radiation therapy, cancer therapy or terminal care? Yes ☐ No ☐
6. Is the patient receiving treatment as a result of a recent major surgery? Yes ☐ No ☐
7. Is the patient receiving mental health/substance abuse treatment? Yes ☐ No ☐
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Continuity of Care.

9. Is this patient expected to be in the hospital when coverage begins or during the next 90 days? Yes ☐ No ☐
10. Please list any other continuing care needs that may qualify for Continuity of Care coverage. If these care needs are not associated with the condition for which you are applying for Continuity of Care coverage, you need to complete a separate Continuity of Care Form.

Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name		Health Care Professional Phone #
Health Care Professional Specialty		
Health Care Professional Address		
Hospital Where Health Care Professional Practices		Hospital Phone #
Hospital Address		
Reason/Diagnosis		
Dates of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

Continuity of Care requests will be reviewed within 10 business days of receipt of all necessary information. Organ Transplant requests may take additional time.

I hereby authorize the above provider to give Allegiance Benefit Plan Management, Inc. any and all information and medical records necessary to make an informed decision concerning my request for Continuity of Care Management. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Please return form to:
Allegiance Benefit Plan Management, Inc
Attention: Claims
PO Box 3018
Missoula MT 59806-3018
Toll Free Fax: 1-866-201-0522

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