Valley Health Plan

Continuity of Care Request

Date: _____ Member phone number: _____

Member Name: _____ Member ID #: _____

Member contact address: _____

Request received by (mark one): ☐ **Phone** ☐ **Email** ☐ **Letter** ☐ **Fax**

Name of Medical Provider: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Continuity of care services being requested (provide summary): _____

_____

_____

_____

Description of member's problem/condition (Select 1):

☐ **Acute Condition**

Diagnosis: _____

☐ **Serious Chronic Condition**

(for example, severe diabetes or heart disease)

Diagnosis: _____

☐ **Pregnancy**

Expected Due Date: _____

Name of Hospital for Delivery: _____

☐ **Terminal Illness**

Diagnosis: _____

☐ **Care of a Child under 3 years.**

Is there a medical diagnosis other than routine care pediatric care please provide:

_____

☐ **An already scheduled surgery or other procedure**

(for example, knee surgery or colonoscopy).

Date of Procedure: _____

Name of Hospital: _____

Medical records provided and attached? ☐ Yes ☐ No

Form Received by: _____ Date received: _____

Sent to UM: ☐ Yes ☐ No Date Sent: _____