

Instructions: To be eligible for Continuity of Care (COC), the member must have received a letter stating the treating provider is no longer participating in the member's plan (please include a copy of the letter); or the member's employer plan changed and member is in an active course of treatment as described below. Please contact Customer Service if there are questions.

Please return completed form and clinical documentation to Intake@Preferredone.com or fax to (763) 847-4014.

MEMBER INFORMATION			
Patient Name		Patient ID #	Date of Birth
Mailing Address		City	State Zip Code
Phone	Email Address		

TREATING PROVIDER INFORMATION			
Requester Contact Name		Phone	Fax
Provider Name (First & Last)	Provider NPI #	Provider Specialty	
Provider Address		City	State Zip Code
Phone	Fax	Email Address	

TREATMENT INFORMATION		
Diagnosis Code(s)	How long has the provider been treating patient?	
Date of Last Visit	Next Scheduled Appointment	Frequency of Visits
Expected Length of Treatment	If Maternity, Expected Date of Delivery	Hospital (if applicable)

Conditions requiring active treatment. Please check all that apply to the member.

- Undergoing a course of treatment for a condition that is life-threatening or could cause permanent harm
- Undergoing a course of institutional or inpatient care
- Scheduled to undergo non-elective surgery
- Pregnant and undergoing a course of treatment for the pregnancy
- Terminally ill, meaning the member has less than 6 months to live and the member is receiving treatment for the illness
- Receiving care from this provider and this provider is the only culturally appropriate provider within 30 miles or 30 minutes
- Unable to speak English and the health plan company does not have a provider in its contracted preferred provider network who can provide care either directly or through an interpreter

When applicable please provide details for above checked item(s).

Provider Signature	Date
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