

Community First Health Plans
Request for Continuity of Care Coverage

Attachment A

Name (Patient/Member)	Attending Physician
Member Number	Physician Phone
Daytime Phone #	Street Address
Name (Person Completing Form)	City / State / Zip
Street Address	Proposed Facility
City / State / Zip	Signature of Proposed Specialist to Serve as PCP

DIAGNOSIS/CONDITION/TREATMENT _____

CERTIFICATION AND MEDICAL AUTHORIZATION

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this request. I certify that the information I furnish in support of this request is true and correct.

Signed (Specialty Care Provider) _____

Signed (member) _____

Mail or fax form to HSM Department, Community First Health Plans, 4801 NW Loop 410, Suite 1000, San Antonio, Texas 78229 – (210) 358-6040

COMMUNITY FIRST HEALTH PLANS USE ONLY
Comments _____ _____ _____
<i>Community First Health Plans</i> <input type="checkbox"/> Accept case <input type="checkbox"/> Reject case Medical Director Signature _____ Date _____