Humana Request for Continuity of Care Form

Certain medical conditions may qualify you to continue receiving treatment from your physician and to be covered by Humana at the same in-network level of benefits for a specific period of time. This form is provided as a service to you to assist you in your request for continuity of care. **Complete and submit this form within thirty (30) days** to initiate a review of your medical condition to determine if you qualify for Continuity of Care.

Examples of situations that might involve continuity of care include (please check any that may apply to you or a family member):

___ Home healthcare services you are currently receiving
___ Durable medical equipment that you are currently using
___ Ongoing active medical treatment, such as chemotherapy, dialysis, hospitalization, etc.
___ Pregnancy
___ Any of the following chronic medical conditions:

- ___ Diabetes
- ___ Multiple Sclerosis
- ___ Cystic Fibrosis
- ___ Cancer
- ___ Congestive Heart Failure
- ___ Coronary Artery Disease
- ___ Kidney Disease
- ___ Chronic Inflammatory Demyelinating Polyradiculoneurophathy (CIPD)
- ___Other - Explain: ______________________________
- ___ Lupus
- ___ Myasthenia Gravis
- ___ Hemophilia
- ___ Dermatomyositis
- ___Asthma
- ___ Amyotrophic Lateral Sclerosis (ALS)

Member Information

	(First)	(Middle I.)	(Last)	Member ID#
Patient Name:				
Subscriber Name:				
Address:				
City:	**State:**		**Zip:**	
Home Phone: ( )		**Work Phone: ( )**		
Birthdate(MM/DD/YY):				
Type of Plan (Check one):	**______HMO**	**______PPO**	**______POS**	
Name of Treating Physician:				
Phone Number for Treating Physician:				

Upon completion, please mail form to:
San Antonio Team
Humana Inc.
P.O. Box 400029
San Antonio, Texas 78229

Or fax this form to the following:
1-800-266-3022

You may receive a phone call from Humana as a follow up to completing and submitting this form.