445 Grant Avenue, San Francisco, CA 94108
www.BalanceByCCHP.com

CONTINUITY OF CARE REQUEST FORM

Member Name		
Date of Birth (mm/dd/yyyy)	Member ID	
Subscriber Name	Subscriber ID	
Address		
City	State	Zip
Home Phone	Work Phone	
Preferred phone number to call during business hours (8 AM – 5 PM)		

Primary Care Physician (PCP)	PCP Phone
Current Diagnosis	

Reason for Requesting Continuity of Care Benefit:

I am requesting continued care from the following terminated or non-participating doctors, hospitals, or other providers:

Provider/Hospital Name	Specialty	Phone Number	Address

Comments (additional information you feel may help us in evaluating your request)

Member Signature **Date**

Fill out if the Member did not complete this form.
Name of Requestor:
Relation to Member:
Requestor's Signature:
Requestor's Phone:

Return by mail to: Continuity of Care Request
Attn: Director of Utilization Management
445 Grant Avenue
San Francisco, CA 94108

Or by Fax: 415-398-3669

For assistance completing this form, call Member Services at 1-888-775-7888