Continuation of Care Form

Anthem UM Services, Inc.

Date: ________________

Instructions: 1. Complete Continuation of Care Request form.
2. Mail form to the address in the state in which the member resides. ***(See bottom of form)***

Patient Information ____
Name Date of Birth

Member Information ____
Name ID Number

____
Address City, State, Zip Code

Telephone: Home: (__ __ __) __ __ __- __ __ __ __ Work: (__ __ __) __ __ __- __ __ __ __

Doctor Information ____
Name Specialty

____
Address City, State, Zip Code

Telephone: (__ __ __) __ __ __- __ __ __ __

Condition Being Treated:

☐ Pregnancy:

Initial Visit Date: ______________________________Due Date: ____________________

☐ Scheduled Procedures, Surgeries or Tests ______________________________________

Date: _______________________________________ Location: ______________________

☐ Post hospital follow-up visits

☐ Other (Specify) ____

How long is the treatment expected to continue? ____

Additional Comments: ____

PLEASE NOTE: THE SUBMISSION OF THIS FORM DOES NOT GUARANTEE BENEFITS. CONDITION(S) MUST MEET CRITERIA FOR CONTINUATION OF CARE, AND MEMBER'S HEALTH BENEFTT COVERAGE MUST PROVIDE CONTINUATION OF CARE BENEFITS

Indiana	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: IN25A-546 P O Box 7101 Indianapolis IN 46207-7101 Fax#: 800-266-3504	***Ohio***	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: 0H0204-A662 4361 Irwin Simpson Rd Mason, Oh 45040 Fax#: 800-266-3504
Kentucky	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint:KY0304A-670 13550 Triton Park Blvd. Louisville KY 40223 Fax#: 800-730-6061	***Wisconsin***	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: N17 W24340 Riverwood Drive Waukesha, WI 53188 Fax# 866-959-2154
Missouri	Anthem UM Services, Inc. ATTN: COC – UM Mailpoint: MOM904-S316 1831 Chestnut Street St Louis, MO 63103 Fax# local: 888-859-3046 Fax# CDHP: 888-224-4902 Fax# CMSi: 866/959-2154		