Application for Continuity of Care

Group Administrators, Ltd.

Date of Notice: _____

Group Name: _____

Employee Name: _____ **Date of Birth:** _____

ID# from your medical ID card: EMP_____

Patient Information:

Name: _____ Date of Birth: _____

Relationship to Employee: _____

Address: _____

A Plan Representative may contact you, please provide the best phone number to reach you:

Home: _____ Mobile: _____

Please return completed form to:

Mail:
Group Administrators, Ltd
Attn: Stacey Nelson
953 American Ln, Ste 100
Schaumburg, IL 60193

Email:
contactus@groupadministrators.com

Send Email

Terminating Provider: _____

Date of Termination: _____

You or your provider (doctor) should complete this form if:

- You are currently receiving medical care from the doctor or facility shown above, and
- You think you qualify for continuity of care *(up to 90 days from the date of this notice or until you no longer qualify)*

With regard to the terminating provider above, is the patient currently:

- Receiving treatment for an acute condition/trauma? Yes ☐ No ☐
- Scheduled for surgery or hospitalization after the date of termination (listed above)? Yes ☐ No ☐
  Date of surgery: _____
- Involved in a course of chemotherapy, radiation, cancer treatment, or terminal care? Yes ☐ No ☐
- Receiving treatment or follow-up care as a result of a recent major surgery? Yes ☐ No ☐
- Receiving dialysis treatment? Yes ☐ No ☐
- Being considered for organ transplant? Yes ☐ No ☐
- Pregnant? (Estimated due date: _____) Yes ☐ No ☐

Primary diagnosis for qualifying concern _____

Patient history _____

Complications, if any _____

Visit history

Date of first visit _____

Date of most recent visit _____

Frequency of visits _____

Hospitalizations

Date of most recent hospitalization, if applicable _____

Previous hospitalizations for primary diagnosis _____

Patient or Guardian signature* _____ **Date** _____

**I have reviewed the information above. To the best of my knowledge, it is true and correct. My signature allows the doctor listed here (or other healthcare professional) to release the medical records needed to complete this review.*