UnitedHealthcare Continuity of Care Procedures for Carolinas HealthCare System Patients

Effective March 1, 2015, Carolinas HealthCare System (CHS) is no longer a network provider for our members.

As previously communicated, members can find contracted facilities at myuhc.com or by calling the Customer Care telephone number on the back of their health plan ID card.

Some members may need to continue receiving services from a CHS physician or facility. A member should follow the Continuation of Care coverage process described below.

Continuation of Care coverage is continued coverage of services for a limited time for specified medical conditions from a non-contracted physician or facility at the benefit level associated with contracted physicians or facility. Members with pre-planned services through CHS hospitals and facilities also may be eligible for in-network benefits for these services during a transition period. Some examples of services for which continuation of care coverage may be available, include but are not limited to, pregnancy services, chemotherapy or radiation treatments and HIV therapies.

The process for a member to determine whether continuation of care coverage is available is as follows:

- Members should use the Continuity of Care Form below.
- The member completes Sections 1 and 2 and the treating physician completes Section 3.
- The Continuity of Care Form should be faxed to 1-800-628-0654 - Attn: Transition of Care. The clinical team in Clinical Care Review will review and respond to the member quickly.

If members have any questions about completing this Continuity of Care form, they should call UnitedHealthcare using the toll-free customer service number on the back of their ID card.
Employee/Applicant:
Continuity of care may enable qualifying existing enrollees covered under UnitedHealthcare to receive care for specified medical conditions for a time-limited period from a newly non-contracted physician or facility at the benefit level associated with contracted physicians and facilities for treatment of ongoing special conditions:

1. In the case of serious medical condition that requires medical care or treatment through the current provider and where failure to provide the current course of treatment through the current provider would place the person’s health in serious jeopardy.
2. This includes, but is not limited to, cancer, acute myocardial infarction and pregnancy.

A transitional period shall extend up to ninety days or until the end of the benefit period, whichever is greater.

Acceptance of this application is not a guarantee of benefits, payment or clinical coverage determination. Payment of services is based on your benefit plan at the time services are provided.
Disclaimer: HOW DO I KNOW IF I AM ELIGIBLE FOR CONTINUITY OF CARE BENEFITS?

- Read & complete section 1 of the application.
- If you answer No to every question, you are NOT eligible for Continuity of Care. Please contact the number on the back of your ID card to have a customer care professional help you in finding a doctor in the UnitedHealthcare network.

THE APPLICATION PROCESS

1. Complete part 2 if you answered YES to any of the questions in Section 1.
   - Proceed to Part 2 only if you answered YES to at least 1 question in Part 1.
2. Complete part 2 of the application.
   - Be sure to sign the authorization form to release your medical records.
3. Have your physician complete section 3 of the application.
   - If you are receiving care from more than one physician, each one must individually complete section 3.
4. Mail the completed application along with relevant medical records to the address noted on the top of this application within 45 days of the date on your notification letter.

SECTION 1 TO BE COMPLETED BY APPLICANT

Are you pregnant or did you deliver less than 60 days ago? □ YES □ NO
Do you have serious medical condition that requires treatment from your current provider? □ YES □ NO
Are you receiving treatment for cancer? □ YES □ NO
Have you recently had an acute myocardial infarction? □ YES □ NO

SECTION 2 TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City State/Zip Code</td>
</tr>
<tr>
<td>Home Phone Number</td>
<td>Work Phone Number</td>
</tr>
<tr>
<td>Employer Name</td>
<td>Plan Group Number</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Patient’s Date of Birth</td>
</tr>
<tr>
<td>Patient’s Relationship to Employee (i.e., spouse, dependent, self)</td>
<td></td>
</tr>
</tbody>
</table>

Are you currently covered by:

- Medicare
- Medicaid

Authorization to release records:
I authorize all physicians and other health care professionals or institutions to provide UnitedHealthcare information concerning medical care, advice, treatment, or supplies for the patient named above. This information will be used to determine the patient’s eligibility for Continuity of Care Benefits under.

Patient’s Signature / Parent or Guardian’s Signature if Applicant is a Minor

Date
**APPLICATION FOR CONTINUITY OF CARE**

**Physician:**
Please fill out and review the entire form before submission to UnitedHealthcare.

### SECTION 3
**TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL CURRENTLY TREATING CONDITION**

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Physician Number</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State/Zip Code</td>
</tr>
<tr>
<td>Date of Last Visit</td>
<td>Next Scheduled Appointment</td>
<td>Frequency of Visits</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Expected Length of Treatment</td>
<td></td>
</tr>
<tr>
<td>If maternity, expected date of delivery</td>
<td>If maternity, name of hospital planned for delivery</td>
<td></td>
</tr>
<tr>
<td>Current active course of Treatment / Comments</td>
<td></td>
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</tbody>
</table>

Signature of Physician: ___________________________ Date: __________

### SECTION 4
**FOR INTERNAL USE ONLY BY UNITEDHEALTHCARE**

<table>
<thead>
<tr>
<th>UnitedHealthcare Representative’s Name</th>
<th>Continuity of Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Approved</td>
</tr>
<tr>
<td></td>
<td>☐ Not Approved (please document reason below)</td>
</tr>
</tbody>
</table>

Comments

☐ UHC ☐ UniFide ☐ Self Funded

UnitedHealthcare Representative’s Signature: ___________________________ Date: __________