Transition of Care/Continuity of Care

For commercial members

New ConnectiCare members/beneficiaries can continue to see a non-participating physician under the following circumstances:

Routine Care/Treatment

If, at the time of enrollment, a member is receiving medically necessary treatment from a provider who does not participate with ConnectiCare, ongoing care will be covered at the in-network level of benefits for 6 months.

Pregnancy

If a member is in her 2nd or 3rd trimester of pregnancy at the time of enrollment and her obstetrician does not participate with ConnectiCare, maternity services will be covered at the in-network level of benefits up until 6 weeks after delivery.

Terminal Illness

If a member is terminally ill at the time of enrollment and they are receiving services from a non-participating provider, services will be covered at the in-network level of benefits through the end of life.

Cancer Treatment

If, at the time of enrollment, a member is receiving chemotherapy or radiation therapy services from a non-participating provider, ongoing care will be covered at the in-network level of benefits through completion of the active treatment plan, or for 6 months, whichever is less.

Coverage Requests for these services should be emailed, faxed or mailed to:

By email,
authreq@connecticare.com

By fax,
Attention: ConnectiCare Clinical Review Department
1-800-923-2882

By mail,
ConnectiCare Clinical Review Department
175 Scott Swamp Road
Farmington, CT 06032

Please see Request for Coverage form on reverse side.

Members should call ConnectiCare's Member Services Department for assistance with transitioning to a participating provider: 1-800-251-7722, Monday - Friday 8 a.m. to 8 p.m., Saturday 9 a.m. to 2 p.m. to 5:00 p.m. To find a participating provider, use our *Find a Doctor* tool at **connecticare.com**.

ConnectiCare

Request for coverage of services out of the ConnectiCare network.

You only need to fill out this form if you are receiving care from a physician who is *not* in the ConnectiCare network.

Please provide the following information:

Member/Beneficiary Name:	Member/Beneficiary ID Number:
Member/Beneficiary Date of Birth:	Member/Beneficiary Phone:
Primary Care Physician Name:	Primary Care Physician Address:
Primary Care Physician Phone:	Primary Care Physician Fax:
Out-of-Network Physician Name:	Out-of-Network Physician Address:
Out-of-Network Physician Phone:	Out-of-Network Physician Fax:
Date of Last Appointment with Out-of-Network Physician:	
Date of Next Appointment with Out-of-Network Physician:	
Diagnosis:	Procedure: (If applicable)
History/Current Treatment/Reason for Request:	

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