RESET

Request for Continuity of Practitioner Care for Medical Benefits

Braven Health members undergoing a course of treatment with a formerly participating practitioner who is leaving the participating network are entitled to request that we consider continuing to cover eligible care at an in-network level of care, if medically necessary, for a period of four (4) months.

Pursuant to state law, benefits may be provided for a longer period of time in the event care is related to pregnancy, oncological care, psychiatric care or post-operative follow-up. Continuation of care benefits do not apply for cases in which: the physician has been terminated based upon the opinion of the plan's medical director that the physician is an imminent danger to a patient or the public health, safety and welfare; termination of a contract is based on a determination of fraud; a breach of contract was made by the physician; or the physician is the subject of disciplinary action by the State Board of Medical Examiners.

Please complete this form, or work with your practitioner to complete this form, and have it mailed, along with appropriate supporting documentation, to:

Continuity of Practitioner Care Coordinator, PP-12T
Braven Health
P.O. Box 420
Newark, NJ 07101-0420

Braven Health Member Name ______________________________

Braven Health ID # ______________________________

Date of Birth (mm/dd/yyyy):______________________________

Address ______________________________

City ______________________ State __________ ZIP __________

Telephone Number:______________________________

May we call you? ☐ Yes ☐ No

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Member or Terminating Practitioner:
Please complete, or have your terminating practitioner complete, the following information.

Name of Terminating Practitioner ______________________________

Practitioner Address ______________________________

Practitioner Telephone Number ______________________________

Reason(s) for visiting this practitioner ______________________________

Are visits related to behavioral health or substance use treatment/recovery? ☐ Yes ☐ No

How often do you see this practitioner? ______________________________

Date of first visit ______________ Date of most recent visit ______________
MM/DD/YYYY MM/DD/YYYY

Have you experienced any health complications as a result of this condition? ☐ Yes ☐ No

If yes, describe
the complications______________________________

Have you been hospitalized for this condition? ☐ Yes ☐ No

If yes, on what date(s)? ______________________________

If you are pregnant, what is your estimated due date: ______________
MM/DD/YYYY

Member Attestation
I have reviewed the above information and attest to its validity to the best of my knowledge.
I understand that continuation of physician care benefits may be granted, if medically necessary, for up to four months from the effective date of the physician's termination from the network. Pursuant to state law, benefits may be provided for a longer period of time in the event care is related to pregnancy, oncological care, psychiatric care or post-operative follow-up. Continuation of care benefits do not apply for cases in which: the physician has been terminated based upon the opinion of the plan's medical director that the physician is an imminent danger to a patient or the public health, safety and welfare; termination of a contract is based on a determination of fraud; a breach of contract was made by the physician; or the physician is the subject of disciplinary action by the State Board of Medical Examiners. My signature below authorizes the referenced physician to release the appropriate medical records in order to complete this review.

Member Signature ______________________________ Date: ______________
MM/DD/YYYY

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Terminating Practitioner:
If you, the terminating practitioner, are completing this form on behalf of your patient, please respond to the questions below and enclose one or more of the following with this request:

- ☐ Copy of diagnosis summary
- ☐ Copy of operative report
- ☐ Copy of pathology report

What is the current treatment plan for this patient?

____

What is the proposed treatment plan for this patient?

____

Practitioner Signature ______________________________ Date: ____________________
MM/DD/YYYY