Harvard Pilgrim Health Care | Continuity of Care / Transitional Care Request Form

If you are a provider or facility leaving the Harvard Pilgrim Health Care network for reasons unrelated to fraud or quality of care, and you are currently treating a Harvard Pilgrim Health Care member or covered dependent, the member may qualify to continue to receive your care with in-network coverage for a specified period of time in accordance with state and federal law.

Patient (member) information		
Patient name:		Date of birth:
Patient address:		
Member ID:	Cell phone #:	Work phone #:
Primary care provider information		
PCP name:		
PCP address:		

Treatment details

The below is to be completed and submitted by the treating health care provider or facility. Please check all that apply. The patient (member):

- ☐ Is Pregnant. Due date: _____
- ☐ Is considered terminally ill (life expectancy < 6 months)
- ☐ Is undergoing active treatment for an acute condition or non-routine treatment for a chronic condition
- ☐ Other: please describe reason for requesting continuity of care

_____

List health care provider or facility leaving the Harvard Pilgrim Health Care network and the requested services		
Health care provider name:		
Diagnosis code:		Procedure code:
Address:		
NPI #:		Phone #:
TIN #:		
Service(s) requested:		Type of specialist:
Start date:	End date:	Expected # of visits:
Name of physician requesting continuity of care (please print):		
Physician signature:		Date:

Contact information (person submitting this form)	
Name:	Phone #:

Return the completed form to:

Harvard Pilgrim Health Care
Attn: Provider Service Center
1 Wellness Way
Canton, MA 02021
Fax: 1-800-232-0816

Print | Clear form field

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