



MEDICARE

## Continuity of Care Request

Group or Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_

**This request form and any applicable medical documentation should be sent via secured fax:**

**904-301-1614**

***Please send one request per fax transmission***

Patient Name: Last			First			MI			Patient Date of Birth:		
Patient Address: Street			City			State			Zip		
Patient Florida Blue Member Number with Prefix:											
Patient Florida Blue Product:											
<input type="checkbox"/> BlueMedicare HMO											
Maternity				Scheduled Surgery				Other Active Treatment			
Date of Most Recent Office Visit:				Date Last Treated For Condition:				Date Last Treated For Condition:			
Expected Delivery Date:				Date of Most Recent Office Visit:				Date of Most Recent Office Visit:			
Obstetrician Name:				Date of Scheduled Procedure:				Diagnosis Code:			
Obstetrician's Florida Blue Provider #:				Diagnosis Code:				Medication/Procedure Code:			
				Procedure Code:				Estimated Completion Date:			
				Surgeon's Name:				Provider's Name:			
				Surgeon's Florida Blue Provider #:				Provider's Florida Blue Provider #:			

**Note:** An updated request form should be submitted for any changes that need to be made to the original request.