AvMed Embrace better health.

CONTINUITY OF CARE AUTHORIZATION FORM for Out of Network Provider
Fax: 800-552-8633;
Phone: 800-452-8633

Please complete the continuity of care authorization for treatment that is active for a specific condition that was diagnosed or treated on or prior to the provider term date.

Member Information		
Last Name:	First Name:	
ID# A	Date of Birth:	
Requesting Provider Information		
Name	Provider # or Tax ID	NPI
Telephone/Ext.	Fax	Contact Person
Service Provider or Facility (e.g., Hospital, Surgery Center, DME Provider etc.) Please include: Name, Address, Tax ID, NPI, Phone/Fax Numbers & Contact Person		
Name	Provider # or Tax ID	NPI
Telephone/Ext.	Fax	Contact Person
Requested Service for Continuity of Care		
☐ Office Procedure	☐ Administration of Medication	
☐ Outpatient Surgery/Treatment	☐ Chemotherapy	
☐ Inpatient Admission	☐ Other	
Diagnosis: ICD Code and Description		
Code	Code	Code
Description	Description	Description
Procedure: CPT Code/HCPCS and Description		
Code	Description	
Code	Description	
Code	Description	
Provide additional information or changes to be made to an existing authorization. Also include supporting chart notes for requested service, documentation of treatment received for specific condition prior to provider Term date, diagnostic tests & lab values when appropriate.		

AN AUTHORIZATION DOES NOT GUARANTEE COVERAGE AND DOES NOT SUPERSEDE ANY MEMBER BENEFIT LIMITS