Continuity/Transition of Care Fertility Treatment Request Form
Colorado

Form completion tips

Complete and submit a *Continuity of Care Form* if you are currently receiving ongoing care or if you have services scheduled. **Please do not complete and submit the form if you are not currently receiving ongoing care or if you do not have upcoming services scheduled.**

You, your current physician, or a member of your physician's staff may complete and submit the form. Please email or fax the completed form to the address/fax number provided at the bottom of this form.

Please complete and submit a *Continuity/Transition of Care Fertility Treatment Request Form* if you are currently receiving treatment for infertility with an Out-of-Network provider.

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Instructions — Complete this form only if you are receiving ongoing care, or are scheduled to receive care, from a provider that does not participate in Anthem Blue Cross and Blue Shield's (Anthem) network. Please complete a separate form for each covered family member who needs to have care transitioned to another provider.

Subscriber information

Last name	First name	M.I.	Subscriber no.
Subscriber employer name	Date active with Anthem: (MMDDYYYY)		

Patient information

Last name	First name	M.I.	Date of birth (MMDDYYYY)
Preferred phone no. ( ) ☐ Home ☐ Cell ☐ Work	Secondary phone no. ( ) ☐ Home ☐ Cell ☐ Work		

Are you a new enrollee to Anthem? ☐ Yes ☐ No If Yes, please fill in the green-shaded areas a) and b). If No, skip to the yellow-shaded area c).

a)	Name of terminating insurance plan	Type of terminating plan
b)	New/existing Anthem plan name	
c)	Provide the name of your doctor or hospital that is currently providing fertility treatment	

Diagnosis (include pertinent history and physical findings)

Medical information

1. Do you have an appointment to see a fertility specialist within the next six months? ☐ Yes ☐ No
If yes, please provide the applicable information below.

Fertility specialist last name	First name	Phone no.		Date of next office visit
Street address	City	State	ZIP code	Reason for visit

2. Do you have any hospitalizations, surgeries or procedures scheduled for fertility? ☐ Yes ☐ No

Date: Type of surgery/procedure: _____

Name/phone no. of physician performing surgery/procedure: _____

Hospital/facility: _____

3. Other needs/comments: _____

If you answered yes to any of the questions above, a nurse will contact you to coordinate your continuity of care, if appropriate.

Signature required

I authorize WINFertility to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Work ☐ Do not leave confidential information on my voicemail

I, (patient's name) hereby authorize my provider to give the WINFertility reviewing unit any and all information and medical records pertaining to my current course of treatment as necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the WINFertility reviewing unit may need to contact my current provider in order to complete my request, and I authorize such communications. I understand that I can help by following up directly with my provider to let them know that I have requested continuity/transition of care and need their cooperation. I also understand that I may revoke (or cancel) this authorization at any time. I understand that I cannot cancel this authorization when this form has already been used to disclose information.

I understand that I am entitled to a copy of this authorization form.

Signature of patient if age 18 or over **X**	Printed name	Date (MMDDYYYY)
Signature of parent or guardian if patient is under age 18 **X**	Printed name	Date (MMDDYYYY)

Please email this completed form to:

WINFertility
Subject: UM INTAKE/CO Continuity/Transition of Care
WINClinicalServices@win-healthcare.com

Or fax the completed form to:
855-255-7198

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