FROM |
arizona
complete health

Continuity of Care Assistance Instructions

The Continuity of Care Department for Ambetter from Arizona Complete Health is dedicated to helping you receive uninterrupted and coordinated care if you are eligible for the continuity of care assistance benefit. To request this benefit, please fill out the Continuity of Care Assistance Request Form located on pages 2 and 3, and return it by fax or mail.

PLEASE NOTE THE FOLLOWING INSTRUCTIONS:

1. Please complete the Ambetter from Arizona Complete Health Continuity of Care Assistance Request Form to the best of your knowledge. Included:
   - Continuity of Care Assistance Instructions
   - Continuity of Care Assistance Request Form
   - Provider Information Request **(optional)**
2. Section 2 of the Continuity of Care Assistance Request Form (page 3) is an optional section of the form that may be completed by your provider of services to assist with your request; however, it will not be accepted without the member's completed Continuity of Care Assistance Request Form.
3. The Continuity of Care Assistance Request Form must be submitted within 30 days of the effective date of the enrollment or within 30 days of the provider's termination.
4. Please fax or mail all forms to the Ambetter from Arizona Complete Health Continuity of Care Department at 1-833-435-7126.

   or:

   Ambetter Continuity of Care Department
   1870 W Rio Salado Parkway
   Tempe, AZ 85281
5. Please contact the Ambetter from Arizona Complete Health Customer Care Center at 1-888-926-5057 (TTY: 711) if you need assistance completing this form or if you have any questions regarding this process.

Each request for continuity of care assistance is considered based on the plan benefit, applicable state regulations, medical appropriateness, and clinical needs. Upon receipt of the Continuity of Care Assistance Request Form, a nurse care manager will be assigned to review your care needs. You will be notified by telephone and/or mail upon receipt of the completed form.

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Continuity of Care

Assistance Request Form

We at Arizona Complete Health understand that you may be obtaining care from a provider who is not contracted with Arizona Complete Health. If you feel you have a special situation and your care cannot be transferred to an Arizona Complete Health network provider on the date of change in your plan, or your new enrollment date with Arizona Complete Health, you may request that Arizona Complete Health review your special situation. Under certain circumstances, you may be entitled to continuation of care with this non-contracted provider.

To request such a review, please provide the information below as completely and accurately as possible to avoid delay in processing your request. You or your authorized representative may complete the form. If possible, please complete Section 1 below, then provide this form to your provider to complete Section 2 to assist us in processing your request for continuation of care.

The Continuity of Care Department may contact you at the number provided below for additional information or to resolve your request. Thank you for your prompt attention to this matter. Please note that filling out the Continuity of Care Assistance Request Form does not guarantee requested services will be covered. Each case is reviewed with guidelines and criteria in place.

Section 1 – Continuity of Care Assistance Request Form	
Member's name:	Subscriber's name:
Subscriber's ID #:	Member's date of birth:
Please check one: ■ HMO ■ POS ■ PPO ■ EPO ■ HSP	
Member's address:	
Member's telephone # (work):	Member's telephone # (home):
Preferred # to call from 8:00 a.m. to 5:00 p.m.:	
CURRENT PROVIDER INFORMATION	
Medical group/Insurance company:	Phone #:
Primary care physician:	Phone #:
Current diagnosis/condition description:	
Current treatment(s):	
NEW PROVIDER INFORMATION (IF YOU HAVE CHOSEN/BEEN ASSIGNED A Arizona Complete Health NETWORK PROVIDER)	
Medical group:	Phone #:
Primary care physician:	Phone #:

Reason(s) for requesting continuity of care assistance	
MY MEDICAL NEED(S) INCLUDE (PLEASE CHECK ALL THAT APPLY.)	
■ 2nd and 3rd trimester pregnancy and immediate post-partum ■ Acute condition	■ Outpatient behavioral services ■ Serious chronic condition ■ Terminal illness
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Name of specialist(s):	Phone #:
Date of scheduled appointment:	Authorization # if available:
Authorized by:	

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OTHER SPECIAL NEEDS OR COMMENTS (ATTACH ANOTHER PAGE FOR ADDITIONAL INFORMATION AS NEEDED.)	
AUTHORIZATION OF INFORMATION	
Member signature:	Date:
IF FILLED OUT BY OTHER THAN THE MEMBER	
Name of requestor: Relation to member:	
Phone #:	Date:

Section 2 – Provider information request (optional)

THIS SECTION IS OPTIONAL, BUT IF COMPLETED IT MUST BE SUBMITTED WITH THE MEMBER'S COMPLETED CONTINUITY OF CARE ASSISTANCE REQUEST FORM. IT IS NOT REQUIRED BUT WILL EXPEDITE THE REVIEW OF YOUR REQUEST.

PATIENT INFORMATION (TO BE COMPLETED BY THE ARIZONA COMPLETE CARE MEMBER)		
Subscriber name:	Arizona Complete Health ID (if available):	
Address:		
Patient (member) name:	Date of birth:	Phone #:
Non-network treating provider name:		Phone #:
Please note that your provider may require you to complete an Authorization for Release of Information.		

PROVIDER INFORMATION (TO BE COMPLETED BY THE PROVIDER)	
Your patient has requested that Arizona Complete Health cover care provided by you for a specific diagnosis and period of time. If you agree to continue to see your patient and accept Arizona Complete Health standard rates, please provide the requested information so that we can evaluate your patient's request. If you are not willing to accept Arizona Complete Health standard rates, please indicate that below.	
Please check one option: ■ Agree to continue to see your patient accepting Arizona Complete Health standard rates. ■ Not willing to continue to see your patient. You may skip section below.	
Diagnosis:	ICD code(s):
Expected duration of transition:	
Treatment/Treatment plan:	
Treatment/Surgical date:	For pregnancies, EDC:
CPT code(s):	
Non-network treating provider name (print):	Phone #:
Tax ID #:	
Non-network treating provider signature:	Date:

Please fax this completed form and any supporting documentation you believe is appropriate to Arizona Complete Health Continuity of Care Department at 1-833-435-7126.

Or you can mail it to:
Arizona Complete Health Continuity of Care Department
1870 W Rio Salado Parkway
Tempe, AZ 85281

Arizona Complete Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Arizona Complete Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Arizona Complete Health Customer Contact Center at **1-888-926-5057 (TTY: 711).**

If you believe that Arizona Complete Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Arizona Complete Health Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Individual & Family Plan members please call 1-888-926-5057 (TTY: 711); Small Business members please call 1-888-926-5122 (TTY: 711). Employer group members please call 1-800-289-2818 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء خطة الأفراد والعائلة الاتصال على الرقم 1-888-926-5057 (TTY: 711)؛ ويرجى من أعضاء الأعمال الصغيرة الاتصال على الرقم 1-888-926-5122 (TTY: 711). يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-800-289-2818 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。個人與家庭計畫的會員請致電 1-888-926-5057 (TTY: 711) 小型企業的會員請致電 1-888-926-5122 (TTY: 711) 。雇主團體的會員請致電 1-800-289-2818 (TTY: 711) 。

French
Aucun service linguistique avec coût. Vous pouvez obtenir un interprète. Les documents peuvent être lus pour vous. Pour obtenir de l'aide, appelez-nous au numéro figurant sur votre carte d'identité. Membres des programmes pour particuliers et familles, veuillez composer le 1-888-926-5057 (TTY: 711). Membres des programmes pour petites entreprises, veuillez composer le 1-888-926-5122 (TTY: 711). Membres du groupe d'employeurs, veuillez composer le 1-800-289-2818 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Mitglieder von Einzel- und Familienpolicen rufen bitte unter 1-888-926-5057 (TTY: 711) an; Kleinunternehmen-Mitglieder rufen bitte unter 1-888-926-5122 (TTY: 711) an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-800-289-2818 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。個人および家族向けプランのメンバーの方は1-888-926-5057（TTY: 711）まで、小規模企業メンバーの方は1-888-926-5122（TTY: 711）までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-800-289-2818（TTY: 711）までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 개인 및 가족 계획가입자분은 1-888-926-5057 (TTY: 711)번으로 전화해 주시고, 소기업가입자분은 1-888-926-5122 (TTY: 711)번으로 전화해 주십시오. 고용주 그룹 가입자분은 1-800-289-2818 (TTY: 711)번으로 전화해 주십시오.

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hólǫ́. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah dóó ła' da hach'į' él'įįh.Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih. T'áá hó dóó ha'áłchíní bił hak'é'ésti'ígíí kojį' hojilnih 1-888-926-5057 (TTY: 711); Small business deiłnínįjí atah nílįįgo éí kojį' hólne' 1-888-926-5122 (TTY: 711). Employer groupǫjí atah nílįįgo éí kojį' hodíílnih 1-800-289-2818 (TTY: 711).

Persian (Farsi)
کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای برنامه انفرادی و خانواده لطفاً با شماره 1-888-926-5057 (TTY: 711) تماس بگیرید؛ اعضای واحد بازرگانی کوچک با شماره 1-888-926-5122 (TTY: 711) تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره 1-800-289-2818 (TTY: 711) تماس بگیرید.

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Участники планов для семей и частных лиц: звоните по телефону 1-888-926-5057 (TTY: 711). Участники планов для малых предприятий: звоните по телефону 1-888-926-5122 (TTY: 711). Участники групповых планов, предоставляемых работодателем: звоните по телефону 1-800-289-2818 (TTY: 711).

Serbo-Croatian

Besplatne jezičke usluge. Možemo vam obezbediti tumača. Možemo vam pročitati vaše dokumente. Ukoliko vam je potrebna pomoć, nazovite broj napisan na vašoj zdravstvenoj kartici. Molimo članove individualnog i porodičnog plana da nazovu 1-888-926-5057 (TTY: 711); molimo članove malog preduzeća da nazovu 1-888-926-5122 (TTY: 711). Molimo članove grupe osigurane preko poslodavca da nazovu 1-800-289-2818 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados de planes individuales y familiares deben llamar al 1-888-926-5057 (TTY: 711); los afiliados de pequeñas empresas deben llamar al 1-888-926-5122 (TTY: 711). Los afiliados del grupo del empleador deben llamar al 1-800-289-2818 (TTY: 711).

Syriac (Assyrian)

ܝܠܦܬܐ ܠܫܢܢܐ ܡܓܢ (ܠܐ ܦܘܪܥܢܐ). ܡܨܝ ܗ̇ ܕܡܘܬܒܠܝ ܢܝܕ ܗܘ ܡܬܪܓܡܢܐ. ܡܨܝ ܗ̇ ܕܡܩܪܝܬ ܐܓܪ̈ܬܐ ܩܕܡ ܥܝܢܐ ܕܝܠܘܟ. ܩܐ ܡܥܘܕܪܢܘܬܐ،
ܩܪܝ ܠܝ ܥܠ ܡܢܝܢܐ ܪܫܝܡܐ ܥܠ ܦܬܩܐ ܕܗܝܝܘܬܘܟ. ܦܪ̈ܫܐ ܦܘܫܐ ܝ ܡܕ̈ܡܝܐ ܕܫܬܐܣܬܐ ܝܢ ܟܡܫܚܠ ܠܗܘܢ ܩܪܝ ܥܠ ܡܢܝܢܐ
1-888-926-5057 (TTY: 711); ܡܕ̈ܡܝܐ ܕܙܥܘܪܬܐ ܕܦܘܠܚܢܐ ܝܢ ܟܡܫܚܠ ܠܗܘܢ ܩܪܝ ܥܠ 1-888-926-5122 (TTY: 711).
ܡܕ̈ܡܝܐ ܕܓܪܘܦܐ ܕܦܠܚܢܐ ܝܢ ܟܡܫܚܠ ܠܗܘܢ ܩܪܝ ܥܠ ܡܢܝܢܐ 1-800-289-2818 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card. Para sa mga miyembro ng Plano para sa Indibiduwal at Pamilya mangyaring tawagan ang 1-888-926-5057 (TTY: 711); Para sa mga miyembro na Maliit na Negosyo, mangyaring tawagan ang 1-888-926-5122 (TTY: 711). Para sa mga miyembro ng grupo ng empleyado, mangyaring tawagan ang 1-800-289-2818 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกแผนบุคคลและครอบครัว กรุณาโทร 1-888-926-5057 (TTY: 711); สมาชิกธุรกิจขนาดเล็ก กรุณาโทร 1-888-926-5122 (TTY: 711) สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-800-289-2818 (TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Các thành viên của Chương Trình Cá Nhân & Gia Đình vui lòng gọi số 1-888-926-5057 (TTY: 711); Các thành viên thuộc Doanh Nghiệp Nhỏ vui lòng gọi số 1-888-926-5122 (TTY: 711). Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-800-289-2818 (TTY: 711).

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