AmeriHealth Caritas Florida

Continuity of Care (COC) Form

To submit requests, please fax completed form to **1-855-236-9281**.

Member name:	Member ID number:
Member date of birth:	Member effective date:
Treatment start date:	Treatment end date:
Name of provider completing form:	

Member information

1. Is the member pregnant?	☐ Yes ☐ No
2. If yes, when is the due date? (mm/dd/yyyy)	/ /
3. Is the member currently receiving treatment for acute trauma?	☐ Yes ☐ No
4. Is the member scheduled for surgery or hospitalization after the effective date with AmeriHealth Caritas Florida?	☐ Yes ☐ No
5. Is the member involved in a course of chemotherapy, radiation therapy, or cancer therapy, or are they a candidate for organ transplant?	☐ Yes ☐ No
6. Is the member receiving treatment as a result of a recent major surgery?	☐ Yes ☐ No
7. Is the member receiving behavioral health services for a serious mental illness?	☐ Yes ☐ No
8. Is the member receiving substance abuse treatment or ongoing treatment for chronic pain?	☐ Yes ☐ No
9. Is the member receiving care for a terminal illness?	☐ Yes ☐ No
10. Please describe above condition(s). If you did not answer "Yes" to any of the above questions, yet request COC, please describe the condition(s) for which there is a request for COC.	

Provider information

Provider name:	Phone number:
Provider specialty:	Provider email:
Provider mailing address:	
Reason for COC/diagnosis:	
Date(s) of admission: / /	Date of surgery: / /
Type of surgery:	
Please describe treatment being received and expected duration (provide in narrative; provide additional clinical information with COC form, as needed):	