Continuation of Care

Request Form

Form must be fully completed to avoid a processing delay. Please print.

Date:

Patient's name (last, first, MI):	Patient's phone: ( ) Best time to call:	Date of birth:	Member ID number:	Gender: M F
Patient's address:				
Your assigned primary care physician:			Other contact information:	

For certain conditions, you may be eligible to continue care with your non-participating provider for a limited time period. Your request will be reviewed based on eligibility for Continuation of Care.

Current attending physician/provider name:		
Physician/provider address:	City:	ZIP code:
Next scheduled appointment date:	Reason for appointment:	
CalViva participating physician: Yes No	Specialist with CalViva: Yes No	
Is patient pregnant?: Yes No If "Yes," expected date of delivery:		
Additional services (dialysis, home health care, medical equipment, etc. Please describe below.): Yes No		

Please tell us why you want help with ongoing care. Write down the type of service(s) you are requesting.

Description/details: _____

_____

_____

Other special needs/comments: _____

_____

_____

You may ask your PCP (doctor) or specialist to fill in their information. Return completed form using the enclosed envelope, or fax it to 1-800-281-2999 or (818) 676-5161 or (818) 676-5387.

State Health Programs • Coordination of Care Unit • PO Box 9103 • Van Nuys, CA 91409-9103

Member signature or name of CalViva Member Service Representative taking request: Date:
To be filled out by the health plan for Continuation of Care requests only. DHCS claims file reviewed to verify claims were paid under the FFS Medi-Cal program for the requested provider. In the absence of DHCS claims data, requested provider was contacted to obtain patient's visit history (see attached).