

Medicare Continuity-of-Care (COC) Request

This form is to request Continuity-of-Care (COC) consideration for a Florida Blue Medicare member.

INSTRUCTIONS:

- Please complete this COC form as soon as the need for COC is identified. **A separate COC form must be completed for each condition** for which the member is seeking COC.
 - **Note: An updated request form should be submitted for any changes to the original request.**
- The provider must send the completed form via secured fax to **1-904-301-1614**.
- **All fields must be completed, including the provider’s signature. Incomplete COC forms will be returned to provider.**

Florida Blue Medicare will review and evaluate the information provided.

PATIENT INFORMATION							
Patient Name (Last Name, First Name, MI)		Florida Blue Member ID Number with Prefix		Date of Birth (mm/dd/yyyy)			
Address		City		State		ZIP Code	
Patient’s Preferred Contact Number				Patient’s Preferred Email Address			
Is patient currently covered by another health insurance carrier?							
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, carrier name: _____							
Florida Blue Medicare Product							
<input type="checkbox"/> BlueMedicare HMO <input type="checkbox"/> BlueMedicare PPO							

PROVIDER INFORMATION							
Provider Name		Florida Blue Provider Number		Provider Contact Name			
Provider Group Name		Provider Group Tax ID		Provider Fax Number		Provider Phone / Extension	
Address		City		State		ZIP Code	

At least one of the following three columns must be completed:

MATERNITY	SCHEDULED SURGERY	OTHER ACTIVE TREATMENT
Date of Most Recent Office Visit	Date Last Treated for Condition	Date Last Treated for Condition
Expected Delivery Date	Date of Most Recent Office Visit	Date of Most Recent Office Visit
	Date of Scheduled Procedure	Diagnosis Code(s)
	Diagnosis Code(s)	Medication/Procedure Code(s)
	Procedure Code(s)	Estimated Completion Date
LOCATION OF SERVICES		
Hospital (Facility) Name	Hospital (Facility) Florida Blue Number	Hospital (Facility) Tax ID Number
Signature of Health Care Provider		Date (mm/dd/yyyy)