KAISER PERMANENTE®

Continuity of Care Request

Kaiser Permanente Utilization Management Operations Center (UMOC)

NAME (Please Print):

Welcome to Kaiser Permanente

You have made a great choice for your health! We value every member and aim to make your transition from your prior insurance company to Kaiser Permanente as smooth as possible.

Each member of your family who is seeking continuity of care will need to submit a separate form under his/her own name.

If this form applies to you, please review the steps under **"What You Need to Do"** and the alerts under **"Please Note"** so that your application can be appropriately considered for Continuity of Care.

What You Need to Do:

If you are seeking continuity of care for a Medical/Surgical or Behavioral Health issue, complete the Patient Section then give the Continuity of Care Form to your health care provider to complete. Additionally, you will also need to request and sign a Medical Release of Information Form from the provider that is treating you for this condition. The information provided in this packet will guide you through the process of initiating your continuity of care request.

Complete this Form:

If you are (a) currently being followed by a health care provider for any of the medical conditions listed below and or are receiving care for behavioral health and (b) would like to request approval to continue seeing that health / behavioral care provider even after beginning your coverage with Kaiser Permanente:

Please check all conditions that apply:

- ☐ Obstetric Care
- ☐ Active Oncologic (Cancer) Radiation or Chemotherapy Treatment
- ☐ Scheduled Surgery
- ☐ Hemodialysis
- ☐ Scheduled Therapy – (Physical, Occupational, and/or Speech)
- ☐ Durable Medical Equipment (DME)
- ☐ C-PAP
- ☐ Bi-PAP
- ☐ Oxygen (except Medicare recipients on oxygen greater than > 18 months)
- ☐ Ongoing Skilled Home Health Care
- ☐ Behavioral Health Care
- ☐ Current Inpatient or Skilled Nursing Facility Confinement
- ☐ Other

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Ask your current health care provider who is treating your current condition to do the following:

☐ **For Medical/Surgical, Homecare, Durable Medical Equipment services complete pages:**

1. Complete the Provider Section of this form
2. Complete the Uniform Consultation Referral Form
3. Sign the Continuity of Care Request Form
4. Include all relevant clinical information to support the service(s) requested
5. Include the signed Medical Release Form
6. Please use one of the following methods to submit your Medical Continuity of Care packet:
   - **Fax** the completed Continuity of Care information packet to Medical at: **1-855-414-1699** in one submission
   - **Send a Secure Email** with the completed Continuity of Care information packet to: **UMOCConfirmation@kp.org**. Please review with your email provider on how to send the information packet securely.

☐ **For Behavioral Health services complete:**

1. Complete the Provider Section of this form
2. Have your provider complete the Uniform Treatment Plan Form
3. Sign the Continuity of Care Request Form
4. Include all relevant clinical information to support the service(s) requested
5. Include the signed Medical Release Form
6. Please use one of the following methods to submit your Behavioral Health Continuity of Care packet:
   - **Fax** the completed Continuity of Care information packet to Behavioral Health at: **1-855-414-1703** in one submission
   - **Send a Secure Email** with the completed Continuity of Care information packet to **BHConfirmation@kp.org**. Please review with your email provider on how to send the information packet securely.

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FOR OFFICE USE: To be completed by Kaiser Permanente *(Please Do Not Remove from Packet)*

Group Information:

Employer Group Name:

Jurisdiction:

Line of Business:

Kaiser Group Number:

Start Date of Kaiser Coverage:

Current Health Insurance Carrier:

Current Health Insurance ID Number:

KP Product Offerings:

Base Plan	☐ SIGNATURE	☐ SELECT	☐ FLEX CHOICE
Middle Plan:	☐ SIGNATURE	☐ SELECT	☐ FLEX CHOICE
Choice Plan:	☐ SIGNATURE		☐ FLEX CHOICE
Other Plan:	☐ SIGNATURE	☐ SELECT	☐ FLEX CHOICE

Please Note:

- Incomplete and/or missing information may cause a delay in the review of your request.
- All forms must be legible; if forms are not legible, we will notify your current provider, which could delay the review of your request.
- Continuity of Care review is based on the information provided by you and your provider in this request. If any information should change, any previous review will become void, and a new request should be submitted immediately.
- Continuity of Care review to consider approval of continuing care is limited to the services requested and directly related to the medical condition described in the request. Services unrelated, but performed by the same physician, will not be covered.
- To receive confirmation of receipt of your Continuity of Care fax document, please ensure to fill out your email address.
- Communication of your request for Continuity of Care will be provided within three business day after your effective date.
- MEDICAL/SURGICAL: Your current provider may contact Kaiser Permanente Utilization Management Department at 1- (800) 810-4766 option 2, with any questions and/or concerns regarding the status of the request.
- BEHAVIORAL HEALTH: Your current provider may contact Kaiser Permanente Behavioral Health Department at 301-552-1212, with any questions and/or concerns regarding the status of the request.

Medical/Surgical, Homecare, Durable Medical Equipment Form

Patient Section – To be completed by the Patient *(Please Print)*

If you are unsure of insurance information,
please ask your company's Human Resources Department.

Today's Date: ☐☐ / ☐☐ / ☐☐☐☐

LAST Name:

FIRST Name: Middle Initial: Date of Birth: (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Member Address:

City: State: ZIP Code:

E-mail Address:

Home Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Work Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Cell Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Is it okay to leave a message? ☐ Yes ☐ No

If yes, specify which number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Provider Section – To be completed by the Provider *(Please Print)*

LAST Name:

FIRST Name:

Provider Mailing Address:

City: State: ZIP Code:

Provider Office Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Provider Office Fax Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐

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Provider Section – Continued

Type of Place for Planned Care:

Location of Service for Planned Care:

☐ **Planned Inpatient**

Date of Planned Procedure / Service:
☐☐ / ☐☐ / ☐☐☐☐

Facility Name:

Address:

☐ **Current Inpatient or Skilled Nursing Facility Confinement**

Expected Discharge Date:
☐☐ / ☐☐ / ☐☐☐☐

Facility Name:

Address:

Contact:

☐ **Outpatient Facility**

Date of Planned Procedure / Service:
☐☐ / ☐☐ / ☐☐☐☐

Facility Name:

Address:

☐ **Outpatient Professional Office**

Date of Planned Procedure / Service:
☐☐ / ☐☐ / ☐☐☐☐

Provider Full Name:

Office Address:

☐ **Ambulatory Surgical Center Facility**

Date of Planned Procedure / Service:
☐☐ / ☐☐ / ☐☐☐☐

Facility Name:

Address:

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Provider Section – Continued

Type of Place for Planned Care:

☐ **Outpatient – (Other)**
Describe _____

_____

Date of Planned Procedure / Service:
☐☐ / ☐☐ / ☐☐☐☐

Location of Service for Planned Care:

Facility Name:

Address:

☐ **3rd Trimester Obstetric Care**

Member Expected Due Date:
☐☐ / ☐☐ / ☐☐☐☐

Delivery Hospital Full Name:

Address:

☐ **Durable Medical Equipment**

Date of Planned Service:
☐☐ / ☐☐ / ☐☐☐☐

Vendor Name:

Address:

Phone Number:

☐ **Skilled Home Health Care**

Date of Planned Service:
☐☐ / ☐☐ / ☐☐☐☐

Home Health Care Agency Name:

Address:

Phone Number:

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Diagnosis Codes – ICD

1. Code		Code Description:	
2. Code		Code Description:	
3. Code		Code Description:	
4. Code		Code Description:	
5. Code		Code Description:	

Planned Procedure Codes – CPT

1. Code		Code Description:	
2. Code		Code Description:	
3. Code		Code Description:	
4. Code		Code Description:	
5. Code		Code Description:	

Durable Medical Equipment– HCPCS

1. Code
2. Code
3. Code
4. Code
5. Code

Indicate type of equipment and how long patient has been using the equipment.

Oxygen Request – HCPCS

1. Code
2. Code
3. Code
4. Code
5. Code

Please include documentation of blood gas study results obtained within 30 days prior to the request.

CPAP and BiPAP Request – HCPCS

1. Code
2. Code
3. Code
4. Code
5. Code

CPAP and BiPAP - The following clinical documentation must be submitted.

1. CPAP Settings
2. Face-to-Face Date: (must take place first and a documentation that the beneficiary continues to use the CPAP/BiPAP device).
3. Sleep Study Test and Titrations Date:

  / /

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Uniform Consultation Referral Form

(Use for Medical, Surgical, Homecare, Durable Medical Equipment)

Date of Referral: ☐☐/☐☐/☐☐☐☐

Patient Information

LAST Name:

FIRST Name: Middle Initial: Date of Birth: (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Member Number: Site Number:

Carrier Information

Name: **Kaiser Foundation Health Plan of Mid-Atlantic States, Inc**

Address:

City: State: ZIP Code:

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Facsimile/Data Medical / Surgical:

855-414-1699

Primary or Requesting Provider

LAST Name: FIRST Name: Middle Initial:

Specialty: Institution/Group:

Provider ID#: 1 Provider ID#: 2 *(If Required)*

Address:

City: State: ZIP Code:

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Facsimile/ Data Number: ☐☐☐-☐☐☐-☐☐☐☐

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Referral Information

Reason for Referral:

Brief History, Diagnosis, Test Results:

Services Desired: Provide Care as Indicated:

- ☐ Initial Consultation Only
- ☐ Diagnostic Test: *(specify)*
- ☐ Consultation With Specific Procedures: *(specify)*
- ☐ Specific Treatment
- ☐ Global OB Care & Delivery
- ☐ Other: *(Explain)*

Place of Service:

- ☐ Office
- ☐ Outpatient Medical/Surgical Center *
- ☐ Radiology ☐ Laboratory
- ☐ Inpatient Hospital *
- ☐ Extended Care Facility *
- ☐ Other: *(Explain)*

** Specific Facility Must be Named.*

Number of Visits: ☐ *If Blank, 1 Visit is assumed.*

Authorization #: *(If Required)*

Referral Date is Valid Until: *(See Carrier Instruction)*
☐☐ / ☐☐ / ☐☐

Signature: *(Individual Completing This Form)*

Authorizing Signature: *(If Required)*

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

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Today's Date:
__/__/____

Carrier or Appropriate Recipient:
Kaiser Permanente Behavioral Health UM
Fax: 855-414-1703

Uniform Treatment Plan Form *(For Purposes of Treatment Authorization)*

Patient Information

PATIENT'S FIRST Name:

Date of Birth: (mm/dd/yyyy):
__/__/____

Kaiser Membership Number:

Authorization Number *(if applicable)*:

Practitioner Information

PRACTITIONER ID# or TAX ID

PRACTITIONER Phone Number:
___-___-____

PRACTITIONER Facility Name:

PRACTITIONER Fax Number:
___-___-____

PRACTITIONER Address:

Date Patient First Seen for This Episode of Treatment: (mm/dd/yyyy):
__/__/____

Level of care being requested: Please specify benefit type:

- ☐ Mental Health
- ☐ Substance Use Disorder
- ☐ Outpatient
- ☐ Intensive Outpatient Program
- ☐ Partial Hospitalization Program
- ☐ Acute IP
- ☐ IP Rehab D
- ☐ Acute IP Detox
- ☐ Residential
- ☐ ECT
- ☐ or TMS
- ☐ Applied Behavior Analysis (ABA)
- ☐ Psychological Testing
- ☐ Biofeedback
- ☐ Telehealth
- ☐ Other

Primary Dx Code:

Secondary Dx Code(s):

Current Treatment Modalities: (check all that apply)

Psychotherapy:

- ☐ Behavioral
- ☐ CBT
- ☐ DBT
- ☐ Exposure
- ☐ Supportive Therapy
- ☐ Problem Focused
- ☐ Interpersonal
- ☐ Psychodynamic
- ☐ EMDR
- ☐ Group
- ☐ Couples
- ☐ Family
- ☐ Other

☐ **Medical Evaluation and Management**

Type of Medications (if not applicable, no response is required):

- ☐ Antipsychotic
- ☐ Anxiolytic
- ☐ Antidepressant
- ☐ Stimulant
- ☐ Injectables
- ☐ Hypnotic
- ☐ Non-psychotropic
- ☐ Mood Stabilizer
- ☐ Other

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Current Symptoms and Functional Impairments:

Rate the patient's current status on these symptoms/functional impairments, if applicable.

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐

Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	☐	☐	☐	☐
Substance Use Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Agitated/Aggressive Behavior	☐	☐	☐	☐
Mood Instability	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐
Eating Disorder Symptoms	☐	☐	☐	☐
Social/ Familial/School/Work Problems	☐	☐	☐	☐
ADL Problems	☐	☐	☐	☐

If requesting additional outpatient care for a patient, why does the patient require further outpatient care:

- ☐ Maintenance treatment for a chronic condition
- ☐ Consolidate treatment gains
- ☐ Continued impairment in functioning
- ☐ Significant regression
- ☐ New symptoms and/or impairments
- ☐ Supportive treatment due to other treatment plan changes
- ☐ Complex psychiatric and medical co-morbidity
- ☐ Complex psychiatric and substance abuse co-morbidity
- ☐ Other

Signature of Practitioner:

Date: (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Date Service is to Begin: (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Number of Sessions Requested: ☐

My signature attests that I have a current valid license in the state to provide the requested services.

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Complete the following if the requuest is for ECT or rTMS:

Provide clinical rationale including medical suitability and history of failed treatments:

Requested Revenue/HCPC/CPT Code(s) Number of Units for each

Complete the following for Applied Behavior Analysis (ABA) Requests (if the carrier classifies ABA as a mental health benefit):

Supervising BCBA Name

Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? ☐ Yes ☐ No

For initial requests, what are specific ABA treatment goals for the patient?

1.
2.
3.

Date of Evaluation by MD/DO: (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

For continuing requests, assessment of functioning (observed via FBA, ABLLS, VB-MAPP, etc.) related to ASD including progress over the last year:

For continuing requests what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child's response to treatment:

1.
2.
3.

Requested Revenue/HCPC/CPT Code(s) Number of Units for each

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Complete the following if the request if for Psychological Testing:

Symptoms/Impairment related to need for testing:

- ☐ Acute change in functioning from the individual's previous level
- ☐ Peculiar behaviors and/or thought process
- ☐ Symptoms of psychosis
- ☐ Attention problems
- ☐ Development delay
- ☐ Learning difficulties
- ☐ Emotional problems
- ☐ Relationship issues
- ☐ Other:

Personality problems

- ☐ School problems
- ☐ Family issues
- ☐ Cognitive impairment
- ☐ Mood related Issues
- ☐ Neurological difficulties
- ☐ Physical/medical signs

Purpose of Psychological Testing:

- ☐ Differential diagnostic clarification
- ☐ Help formulate/reformulate effective treatment plan.
- ☐ Therapeutic response is significantly different from that expected based on the treatment plan.
- ☐ Evaluation of functional ability to participate in health care treatment.
- ☐ Other: (describe)

Substance use in last 30 days: ☐ Yes ☐ No

Diagnostic Assessment Completed: ☐ Yes Date ☐☐ / ☐☐ / ☐☐☐☐ ☐ No

Patient substance free for last ten days ☐ Yes ☐ No

Has the patient had known prior testing of this type within the past 12 months? ☐ Yes ☐ No

If so, why necessary now? ☐ Unexpected change in symptoms ☐ Evaluate response to treatment ☐ Assess functioning ☐ Other

Names and Number of Hours of each requested test

If appropriate, complete this section:

Reason(s) why assessment will require more time relative to test standardization samples?

- ☐ Depressed Mood ☐ Vegetative Symptom ☐ Processing Speed
- ☐ Performance Anxiety ☐ Expressive/Receptive Communication Difficulties ☐ Low Frustration Tolerance
- ☐ Suspected or Confirmed grapho-motor deficits
- ☐ Physical Symptoms or Conditions such as:
- ☐ Other:

Requested Revenue/HCPC/CPT Code(s) Number of Units for each

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Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitilization:

Primary reason for request or admission: (check one)

☐ Self/Other Lethality Issues ☐ Violent, Unpredictable/Uncontrolled Behavior ☐ Safety Issues ☐ Eating Disorder
☐ Detox/Withdrawal Symptoms ☐ Substance Use ☐ Psychosis ☐ Mania ☐ Depression
☐ Other _____

Why does this patient require this higher level of care at this time?
(Please provide frequency, intensity, duration of impairing behaviors and symptoms):

Medication adjustments (medication name and dose) during level of care:

Barriers to Compliance or Adherence: _____

Prior Treatment in past 6 months:

☐ Mental Health ☐ Substance Use Disorder ☐ Inpatient Residential ☐ Partial Intensive Outpatient ☐ Outpatient

Relevant Medical issues (if any):

Support System/Home Environment:

Treatment Plan (include objectives, goals and interventions):

Patient Membership Number _____

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If Concurrent Review–What progress has been made since the last review

Why does member continue to need level of care

Discharge Plan (including anticipated discharge date)

Complete the following if the request is Substance Use related:

rate the patient's current severity/risk and current need for treatment services intensity on these Dimensions:

	Low	Medium	High
1. Acute intoxication and/or withdrawal potential	☐	☐	☐
2. Biomedical conditions and complications	☐	☐	☐
3. Emotional, behavioral, or cognitive conditions and complications	☐	☐	☐
4. Readiness to charge	☐	☐	☐
5. Relapse, continued use, or continued problem potential	☐	☐	☐
6. Recovery/living environment	☐	☐	☐

Add details or explanation needed for each dimension

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Complete the following if substance use is present for higher level of care requests:

Type of substance use disorder

Onset: ☐ Recent ☐ Past 12 Months ☐ More than 12 months ago

Frequency: ☐ Daily ☐ Few Times Per Week ☐ Few Times Per Month ☐ Binge Pattern

Last Used: ☐ Past Week ☐ Past Month ☐ Past 3 Months ☐ Past Year ☐ More than one year ago

Consequences of relapse: ☐ Medical ☐ Social ☐ Housing ☐ Work/School Legal

☐ Other

Urine Drug Screen: ☐ Yes ☐ No

Vital Signs:

Current Withdrawal Score: (CIWA) COWS) or ☐ Symptoms (check if not applicable)

History of: ☐ Seizures ☐ DT's ☐ Blackouts ☐ Other ☐ Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:

Height: Weight: % of NBW

Highest weight Lowest weight Weight change over time (e.g. lbs lost in 1 month)

If purging, type and frequency Potassium Sodium Vital signs

Abnormal EKG Medical Evaluation ☐ Yes ☐ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues:

Please include any current medical/physiological pathologic manifestations:

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