FOR INTERNAL USE ONLY: To be completed by Sales Representative

CONTINUITY OF CARE

scan™

PLEASE PRINT LEGIBLY

Member Last Name:		Effective Date:
Member First Name:		DOB:
Phone:	Alternate Phone:	
Emergency Contact:	Emergency Contact Phone:	

EXISTING SERVICES:

Please provide as much information as possible about the continuity of care needs expressed during the enrollment conference.

☐ Urgent Continuity of Care Need (appointment within 1st week of effective date)

☐ Currently Inpatient (Hosp/SNF) Facility:	Discharge Date:

Specialist Name:	Phone:	Appt:
Specialist Name:	Phone:	Appt:
Home Health:	Phone:	Schedule:
Dialysis Center:	Phone:	Schedule:
Procedure & Provider:		Phone:

Procedure Appt:

DURABLE MEDICAL EQUIPMENT:

☐ CPAP/Nebulizer ☐ Oxygen ☐ CGM ☐ Hospital Bed ☐ Ostomy

☐ Other (briefly describe): _____

MEDICATION ASSISTANCE:

Does the member have any current medications that require **prior authorization** or **not on the SCAN Formulary**? ☐ Yes ☐ No

If **Yes**, please enter the names(s) of the medications(s).

_____

_____

ADDITIONAL NEEDS:

☐ Housing concerns ☐ Unable to afford food ☐ Unable to afford medication(s)

Requests for continuity of care are reviewed on a case-by-case basis with the goal to establish and continue care with an in-network provider. A SCAN Care Navigator will contact the member near their effective date to assist with coordinating care.

Fax completed form to 562-552-9379