



South Carolina

BlueCross BlueShield of South Carolina  
is an independent licensee of the  
Blue Cross and Blue Shield Association

**Continuation of Care for Serious Medical Conditions**

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Under South Carolina law<sup>1</sup>, you may be eligible for in-network level benefit coverage from your insurance plan if the provider is no longer in your plan’s network. This includes services rendered by physicians or performed in facilities that have withdrawn or been terminated from your plan’s network for any reason other than suspension or revocation of the provider’s license. This coverage is valid for up to 90 days or until the end of your current benefit period, whichever is longer.

This ensures continuity of care for Serious Medical Conditions, where failure to provide the current course of treatment through your current provider would place your health in serious jeopardy. A Serious Medical Condition includes cancer, acute myocardial infarction and pregnancy.

To submit a request for Continuation of Care coverage, complete this form with your physician. Return it via mail or fax it to 803-870-8339:

BlueCross BlueShield of South Carolina  
I-20 East at Alpine Rd  
Attn: Appeals AX-F25  
Columbia SC 29219

We will review your request and notify both you and your provider of our decision in writing.

**Insurance Card ID Number:** \_\_\_\_\_

**Member’s Name:** \_\_\_\_\_  
First Name Middle Initial Last Name

**Member’s Address:** \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State ZIP Code

**Telephone Number:** \_\_\_\_\_ - \_\_\_\_\_  
Area Code

**Name of Physician and/or Provider Leaving Blue Cross and Blue Shield of South Carolina’s Network:** \_\_\_\_\_

\_\_\_\_\_  
**Member or Legal Guardian’s Signature if Member is Under 16 Years of Age** **Date**

<sup>1</sup> South Carolina Code of Laws, Section 38-71-243, Continuation of Care for Serious Medical Conditions  
Cont. of Care Req. 2011

**To Be Completed by the Member's Physician or Authorized Provider**

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**Diagnosis:** \_\_\_\_\_

Description and ICD-9 Code(s)

**Provider Specialty:** \_\_\_\_\_

**Treatment Plan:** Current course of treatment that would require Continuation of Care.

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(We require medical records for the six months prior to the request for Continuation of Care. You must include this information, when applicable: office notes, consultation notes and treatment plan; history and physical, operative report and discharge summary; and laboratory reports and X-ray/MRI/CT reports. We may request additional information as necessary.)

The member's policy permits Blue Cross and Blue Shield of South Carolina to request medical records and other related information for reimbursement processing purposes.

**Provider's Name (please print):** \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician or Authorized Provider

\_\_\_\_\_  
Date

**By signing this form, I attest that the member's condition is a Serious Medical Condition and acknowledge that, except for any applicable deductible, copayment or coinsurance, I will not bill or otherwise hold the member financially responsible for services provided for the Continuation of Care.**