



Re: Continuity of Care

We understand the importance of maintaining continuity in your healthcare, especially when there are changes in your network status. To alleviate any potential disruption to your ongoing treatment, Boon-Chapman Benefit Administrators has established a **Continuity of Care** program. This program ensures that any eligible member undergoing a current course of treatment continues to receive care at the in-network level of benefits, even if network changes occur.

For example, if you are in the middle of a physical therapy treatment plan, we will ensure that your visits are covered at the in-network rate until your treatment is completed.

How to Apply for Continuity of Care:

To help us identify your treatment plan and process claims accordingly, we kindly ask that you follow the steps below:

1. Complete the attached Continuity of Care form.
2. Submit the form via email to our Medical Management Team at Prime Dx PDX@primedx.com.

Once we receive your submission, Prime Dx will contact your healthcare provider to confirm that the approval is in place and ensure that there is no disruption to your treatment.

We encourage you to reach out to Prime Dx at **800-477-4625** as soon as possible, rather than waiting until your next appointment date. This allows sufficient time for our team to coordinate with your provider and ensure your upcoming visits go smoothly.

Important Note:

For your privacy and in compliance with HIPAA regulations, we ask that you contact Prime Dx directly regarding your treatment plan. Please do not reach out to your Human Resources department, as we are required to maintain confidentiality and can only discuss your treatment details directly with you.

If you have any questions or need further assistance, please do not hesitate to contact Prime Dx.

Thank you for your attention to this matter. We are committed to supporting your healthcare needs and ensuring continuity of care throughout your treatment.



*****PLEASE COMPLETE THE FOLLOWING FORM IN ITS ENTIRETY*****

Employer Name:

Employee Name:

DOB:

Address:

Contact Number:

Patient Name:

DOB:

Relation to Employee:

Medical History and Treatment

Medical condition (e.g. chronic conditions, pregnancy, high risk procedures):

Physician:

Address:

Phone:

Facility:

Address:

Description of Current Treatment(s):

Expected duration of treatment, including upcoming surgeries/hospitalizations: