AmeriHealth
Request for Continuation of Care

Member ID Number: _____

Subscriber Name: _____

Group Number: _____

Group Name: _____

Effective Date of Coverage: _____

PATIENT INFORMATION:

Name:_____Date of Birth: _____

Address: _____

_____

Zip Code: _____Home Telephone: (____)_____

PROVIDER INFORMATION:

Doctor's Name: _____

Address: _____

_____

Specialty: _____ Phone Number: (___) _____

Condition Being Treated: _____

How long has the doctor been treating the patient for this condition?

_____Years _____ Months _____ Visits

How long is the treatment expected to continue? _____Years _____ Months

Additional Comments:

Return this form to the following location:

CMC Precertification Department
1901 Market Street, 30th Floor, Philadelphia, PA 19103

FAX: 215-241-0257