AmeriHealth NEW JERSEY

Please Mail To:
AmeriHealth New Jersey, Attn: Continuation of Care
259 Prospect Plains Road, Bldg M
Cranbury, NJ 08512
FAX: (609) 662-2559

Continuation of Care Request Form

AmeriHealth New Jersey - Clinical Services Department

Date:	Form completed by:	Phone #:

REASON FOR REQUEST:

☐ Member newly enrolled with AmeriHealth NJ (Must be submitted within 30 days of effective date)
☐ Provider no longer participates with the AmeriHealth NJ Network *(must not have been termed for Cause by the Plan)*

Non-participating Providers must agree that all Covered Services provided during this transition period shall be provided under the same terms and conditions applicable for AmeriHealth Participating Providers.

MEMBER INFORMATION:

Member ID #:	Effective Date of Coverage:
Previous Insurance Carrier:	Was Provider participating?
Subscriber Name:	Plan Type:
Patient Name:	Date of Birth:
Street Address:	City, State, Zip:
Home phone #:	

DOCTOR INFORMATION:

Doctor Name:	NPI or TIN:
Street Address:	City, State, Zip:
Office phone #:	Specialty:
Office contact person:	

Diagnosis/Condition being treated (include ICD-9):

CPT code(s) for service or procedure being requested (CPT codes and DOS are required if this is a post-op request, or if a surgery/procedure has already been scheduled.): _____

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

How many visits are being requested? _____ Visit(s)

How often is patient being seen? _____ Weekly/Monthly/Quarterly

When is the patient's next appointment? _____

PLEASE SUBMIT LAST OFFICE VISIT NOTE, AND ANY RELEVANT CLINICAL DOCUMENTATION.