RESET

CONTINUITY OF CARE COVERAGE AGREEMENT

As outlined in our *Credentialing and Recredentialing Policy for Participating Physicians and Healthcare Professionals,* we allow primary care physicians (i.e., family practitioners, pediatricians and internal medicine) and specialists who elect to limit their practices to providing services in their offices to satisfy the policy's requirement to obtain participating hospital admitting privileges by establishing an arrangement with other, participating acute care physician(s) or physicians' group(s) to care for his/her patients who require acute care at a network hospital.

The admitting physician(s)/physicians' group(s) must have the same or similar specialty, must participate in the same network(s), and must have admitting privileges at an acute care hospital that participates in the appropriate network(s) for patients being treated.

By completing, signing and returning this form, you and the physician(s)/physicians' group(s) identified attest that such an arrangement has been established. This form will be included in your credentialing file and reviewed by our credentials committee.

Completed and signed forms may be submitted to andros:

- By email to credentialing@andros.co
- By fax to **1-877-437-2909**

I, the applicant, in accordance with our *Credentialing and Recredentialing Policy for Participating Physicians and Healthcare Professionals,* have arranged for patients requiring hospitalization to be admitted under the care of the physician(s)/physicians' group(s) noted below at the network hospital or BlueCard® hospital noted below.

To ensure continuity of care, I, the applicant, working with the admitting physician(s)/physicians' group(s) noted below will:

- Provide all relevant current and past medical history and pertinent records.
- Obtain notification of discharge and a copy of the hospital discharge summary.
- Make arrangements for a follow-up appointment within an appropriate time frame.

_____ _____
(Applicant's name please print) *(Applicant's Type 1 NPI number)*

Applicant Signature: _____ Date: _____/ _____/ _____
MM DD YYYY

I/we, the admitting physician(s)/physicians' group(s) agree to the above arrangement.

To ensure continuity of care, I/we, the admitting physician(s)/physicians' group(s), will provide to the applicant noted above:

- All medical notes and pertinent hospital records.
- Notification of discharge and a copy of the hospital discharge summary.

Name: _____ Type 1 NPI: _____

Specialty:

Group Name: _____ Type 2 NPI: _____

Network/BlueCard® Hospital Name: _____

Signature: _____ Date: _____/ _____/ _____
MM DD YYYY

Name: _____ Type 1 NPI: _____

Specialty:

Group Name: _____ Type 2 NPI: _____

Network/BlueCard® Hospital Name: _____

Signature: _____ Date: _____/ _____/ _____
MM DD YYYY