Martin's Point

GENERATIONS ADVANTAGE

Continuity of Care Form

Your health is our top priority. To prevent coverage gaps during your transition to your Martin's Point Generations Advantage plan, please complete this form if you have upcoming appointments or procedures scheduled within the first 90 days of enrollment in your new plan. **NOTE: Please do not use this form for prescription medications or providers who are ending their participation in our network.**

1 Member Information

I am: ☐ A new Martin's Point Generations Advantage Member
OR
☐ An existing member switching to another Martin's Point Generations Advantage plan

Member name: _____

Date of birth: _____ Generations Advantage Member ID Number: _____

Address: _____

_____

City: _____ State: _____ ZIP code: _____

Home phone: _____ Cell phone: _____

2 Screening Questions for Continuity Care

1. Do you have any hospitalizations scheduled within the first 90 days after your effective coverage date? ☐ Yes ☐ No
2. Do you have any procedures scheduled within the first 90 days after your effective coverage date? ☐ Yes ☐ No
3. Do you have any appointments scheduled with any providers (other than your Primary Care Provider) within the first 90 days after your effective coverage date? ☐ Yes ☐ No
4. Are any of your medical providers out of your Generations Advantage plan's network? ☐ Yes ☐ No
5. Are you currently receiving any equipment or supplies from an out-of-network Durable Medical Equipment (DME) supplier (e.g., oxygen, CPAP, insulin pump, continuous glucose monitor (CGM), ostomy or catheter supplies)? ☐ Yes ☐ No
6. Are you pregnant? ☐ Yes ☐ No
7. Are you receiving treatment for a terminal illness? ☐ Yes ☐ No

If you answered "No" to all of the above questions, you do not need to complete this form. STOP

If you answered "Yes" to any of the above, proceed to Section 3.

3 Provider Information

Providers I am seeing in the first 90 days after enrollment: If you have more than two providers, please list their information on a separate sheet of paper and return it with your form.

Provider #1 Hospitalization/Procedure/Appointment Date: ____/____/_____

Date you began seeing this provider for this course of treatment: ____/____/_____

Provider name: _____

Provider address: _____

Provider phone: _____

Reason for visit: _____

Is provider out of network? ☐ Yes ☐ No ☐ Unsure

Provider #2 Hospitalization/Procedure/Appointment Date: ____/____/_____

Date you began seeing this provider for this course of treatment: ____/____/_____

Provider name: _____

Provider address: _____

Provider phone: _____

Reason for visit: _____

Is provider out of network? ☐ Yes ☐ No ☐ Unsure

4 Care Management Questions

Were you working with a nurse or social work care manager with your previous health plan? ☐ Yes ☐ No

If yes, what health care needs were being addressed?

_____

Would you like to be contacted by the Care Management Department at Martin's Point Health Care to discuss your health care needs? ☐ Yes ☐ No

I authorize Martin's Point Health Care to leave confidential information on my voicemail at the number(s) provided on the form above.

Please check all that apply: ☐ Home ☐ Cell ☐ Do not leave confidential information on my voicemail

5 Signature: _____ Date: ____/____/_____

6 Returning Your Form

Please use the enclosed envelope to return this form by mail to:

Health Management Department, Martin's Point Health Care, PO Box 9746, Portland, ME 04104

7 Have Questions? Need Assistance?

If you have any questions or need assistance completing this form, call the Member Services number on the back of your member ID card (1-866-544-7504 (TTY: 711).