MASSACHUSETTS
LABORERS' HEALTH & WELFARE FUND

CONTINUITY OF CARE REQUEST FORM

We offer eligible members temporary, continued coverage, when undergoing an eligible treatment from a health care provider or facility who is no longer part of your plan's network. If coverage is approved, you can complete your course of treatment with the out-of-network provider/facility or transfer safely to an in-network doctor or facility. Use the attached form to submit Continuity of Care requests within 90 days of your transition needs.

What Type of Treatment is Eligible for Continuity of Care?

You may submit a request for temporary continued coverage by an out-of network provider or facility if you:

- Undergoing treatment from a provider or facility for a **serious and complex condition**, defined as:
    - In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
    - In the case of a chronic illness or condition, a condition that is:
        a) Life-threatening, degenerative, potentially disabling, or congenital; and
        b) Requires specialized medical care over a prolonged period of time.
- Undergoing a course of institutional or inpatient care from the provider or facility.
- Scheduled to undergo **nonelective** surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery.
- Pregnant and undergoing treatment for pregnancy from the provider or facility.
- Terminally ill and receiving treatment for such illness from the provider or facility

How long can Continuity of Care continue?

If the Fund approves your request to continue care with an out-of-network provider or facility, services will be authorized for a period of 90 days or until care has been completed or transitioned to a participating health care professional, whichever comes first.

Questions?

Contact the Fund office at (800) 342-3792 or by email at claims@mlbf.org

PO Box 1501
1400 District Avenue
Suite 200
Burlington, MA 01803

(781) 272-1000
(800) 342-3792

(781) 238-0703

claims@mlbf.org

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Continuity of Care Request Form

Patient Information:

Patient Name:	Member ID#
Patient Address:	
Date of Birth:	Telephone number:

Physician Information:

Physician Name:	Physician Phone Number:
Physician Address:	
Office Contact Name:	Physician Date of Termination:

Treatment Information:

Diagnosis:	Date of Surgery/Admission:	Facility Name:
Description of Treatment Plan and Expected Duration:		
Date of Last Appointment:	Date of Next Appointment:	Expected No. of Visits

I hereby authorize the above healthcare professional to give the Massachusetts Laborers' Health and Welfare Fund any and all information and medical records necessary to make an informed decision concerning my request for continuity of care benefits. I understand I am entitled to a copy of this authorization.	
Signature of Patient, Parent, or Guardian:	Date:

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