Vaya Health

# Member Continuity of Care Request Form

Complete this form to request payment for continued treatment of a Vaya Health (Vaya) member at the network level as an out-of-network provider. Email the signed form to provider.info@vayahealth.com.

## Member Information

Member Name: _____ Phone: _____

Medicaid ID #: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

## Provider Information

Name (Treating Physician or Other Health Care Professional): _____

Billing NPI/TIN: _____ Phone: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Facility Name: _____ Facility NPI or TIN: _____

Facility Phone: _____ Facility City and State: _____

## Treatment Information

Date of Last Visit: _____ Next Scheduled Appointment: _____

Frequency of Visits: _____

Qualifying Diagnosis with ICD-10 code: _____

Expected Length of Treatment: _____

(If Maternity) Expected Date of Delivery: _____

(If Terminal Illness) Current Estimated Life Expectancy: _____

**Treatment Type** (select all that apply):

☐ Life-threatening condition
☐ Acute condition
☐ Transplant
☐ Ongoing treatment (specify):
☐ Inpatient/confined upcoming surgery
☐ Disabled/disability
☐ Terminal illness

_____

**Current Condition and Associated Treatment Plan**

*Include a brief statement and all relevant CPT codes. If there are additional conditions and treatment plans that may qualify for Continuity of Care coverage, please list below or attach relevant documentation to this form.*

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We understand you are not, or soon will not be, a participating provider in the Vaya network. The member named above is receiving treatment for the above medical condition from you and is seeking continued coverage at the network benefit level. If the member is eligible, you agree to (1) provide the covered service, including any follow-up care covered under the member's plan, for the applicable timeframe; (2) follow Vaya policies and procedures; (3) upon request, share information about the member's treatment with us; (4) if applicable, make referrals for services, including laboratory services, to Vaya network providers or ask for our approval before referring a member to an out-of-network provider; and (5) if applicable, request any required prior authorization before the services are rendered.

**For providers leaving the Vaya network:**

The terms and conditions of your network participation agreement will continue to apply to the covered service, including any follow-up care covered under the member's plan. Payment under your network agreement, along with any copay for which the member is responsible under the plan, is payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Vaya, or any payor or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

**For out-of-network providers:**

If the member is eligible for treatment under Continuity of Care provisions, we will provide coverage at the network benefit level. Payment will be consistent with the member's benefit plan. If coverage at the network benefit level is available, you agree to accept payment from Vaya, along with any copay for which the member is responsible under the plan, as payment in full for the covered service. You will neither seek to recover nor accept any payment in excess of this amount from the member, Vaya, or any payor or anyone acting on their behalf, regardless of whether such amount is less than your billed or customary charge.

Signature of Health Care Professional _____ Date _____

Printed name _____