MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS®

Request for Continuity of Care

FOR MPIHP INTERNAL USE ONLY:

Participant Services Representative Name and Ext. _____

Health Plan Effective Date: _____

Participants should keep a copy for their records and send the completed form as soon as possible, but no later than January 31, 2017, to:

By Mail:
Motion Picture Industry Health Plan
Attn: MPIHP - Continuity of Care
P.O. Box 1999
Studio City, CA 91614-0999

By Fax: 818-255-7595 Attn: MPI Continuity of Care

Or call the Motion Picture Industry Health Plan's ("MPIHP") Participant Services Center at 888-369-2007 (opt. 2, to speak with a representative) if you have any questions or concerns regarding this request form.

1. Participant Identification

Participant Name:_____ Participant SSN: _____

Date of Birth:_____/_____/_____

Street Address:_____ City:_____

State, ZIP Code:_____ Home Phone: _____

2. Patient's Continuity of Care Information (1 patient per form please)

Patient Name:_____ Date of Birth: _____/_____/_____

Relationship to Participant: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child

Home Phone: _____

3. Patient's Medical Information (to be completed by provider)

Current Treating Physician requesting Continuity of Care:

Name:_____ Phone: _____

Address: _____

Treating Physician Specialty: _____

NOTE: MPIHP may request medical information in order to evaluate this continuing care request. The determination for your Continuity of Care request will be made once the information has been received and reviewed.

3. Patient's Medical Information, continued

Condition or Diagnosis being treated:

_____

Explain the reason for the Continuity of Care request:

_____

_____

Where is the treatment taking place:

_____

When did care start with treating physician? (Date) _____

If maternity, expected date of delivery: _____

Hospital: _____

Are there any outstanding surgeries planned at this time? ☐ Yes ☐ No
If **yes**, please list type(s) of surgery planned and dates:

_____

Is patient hospitalized now? ☐ Yes ☐ No

If **yes**, please list Provider's Name: _____

Address _____ Phone: _____

4. Additional Medical Information Regarding Patient's Care in Progress (to be completed by provider)

_____

5. Provider Signature

Provider: _____

Provider Signature: _____

Date: _____

5. Patient Certification, Authorization, and Signature

I certify that all statements on this and all accompanying documents are true, correct, and complete to the best of my knowledge and belief. I hereby authorize any physician, healthcare facility, other provider of health care, insurance carrier, hospital or medical service plan to provide MPIHP all information pertaining to any illness, injury or condition, examinations or treatment, including records of billings, benefits or payments, which this patient received at any time. This information is collected to evaluate and process this request, and this authorization will expire upon the later of the completion of the request process or one year from the date of signature. The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity, and may no longer be protected under federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization and that it may be revoked at any time by submitting my revocation in writing to the entity providing the information. I may request to review and copy this form and/or the information described in or released by this

form. I understand that, except as provided in 45 C.F.R. 164.508, health care benefits, payment, enrollment or eligibility for benefits (as provided for in the applicable plan documents) may not be conditioned on whether I sign this authorization. The revocation will not have any effect on any actions or release of information taken before the revocation is received or where this authorization has already been relied upon.

Patient: _____

Patient Signature: _____

Date: _____