EWBTF
Electrical Workers Benefit Trust Fund

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1828 North Meridian Street – Suite 103, Indianapolis, IN

Request for Continuity of Care Benefits and Release of Information

Electrical Workers Benefit Trust Fund provides Continuity of Care benefits to qualifying Eligible Persons when a provider or facility PPO-Network arrangement is terminated. Continuity of Care benefits must be approved by the Fund and can apply for up to 90 days after a "Continuity of Care Notice" is provided by the Fund, if the patient qualifies as a "continuing care patient." These qualifications include meeting one or more of the following criteria: (a) treatment for a serious and complex condition; (b) undergoing institutional or inpatient care; (c) scheduled to undergo non-elective surgery (including related postoperative care); (d) pregnancy or pregnancy treatment; or (e) terminal illness. Requests for Continuity of Care are subject to Utilization Review to determine qualifications as a "continuing care patient."

This form must be completed to be considered for Continuity of Care benefits. Please send the completed form to the address/fax number shown above.

Participant Name:	ID#/SSN:	Date of Birth: / /

Patient Information

Name:	Relationship to /Participant:	Date of Birth: / /
Address:	City:	State: Zip:
Cell Phone:	Home/Alternate Phone:	

Medical Information

Provide a brief description of the condition, diagnosis, and course of treatment for which the patient is seeking Continuity of Care benefits.

Is the patient receiving care for a pregnancy?	Yes	No	If yes, estimated due date: / /
Is there a surgery scheduled or recently undergone?	Yes	No	If yes, date of surgery: / /
Does the patient have physician appt. scheduled?	Yes	No	If yes, date of appointment: / /
Is the patient currently on a transplant list?	Yes	No	If yes, please provide copy of approval letter

Physician/Provider Information

Physician/Provider Name:	Address:	Phone:
Name of Facility (hospital, DME, group):	Date of Last Visit: / /	Date of Next Visit: / /

Physician/Provider Name:	Address:	Phone:
Name of Facility (hospital, DME, group):	Date of Last Visit: / /	Date of Next Visit: / /

Physician/Provider Name:	Address:	Phone:
Name of Facility (hospital, DME, group):	Date of Last Visit: / /	Date of Next Visit: / /

I hereby authorize the NECA-IBEW Welfare Trust Fund and/or its designee to utilize the foregoing information provided and obtain any additional information and/or medical records from the above physician(s)/provider(s) in connection with making a decision regarding my request for Continuity of Care

Signature of Patient or Guardian: **Date:** / /

Office Use Only

Approved: Yes No

Date Reviewed: / /