Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Member Request for Continuity of Care

Please complete this form if you are currently receiving medical care from physician(s) that are no longer listed in your provider directory and you would like assistance in continuation of care. Continuity of Care, for covered services, may be available for up to 90 days.

Group Name ______________________

Group Number ______________________

Employee Name (Last, First, Middle Initial) ______________________

ID Number/Social Security Number ______________________

Date of Birth ______________________

Patient Information

Patient's Name (Last, First, Middle Initial) ______________________

Date of Birth ______________________

Relationship to Employee ______________________

Patient's Street Address ______________________

City ______________________

State ______________________

Zip Code ______________________

Phone Numbers: Home ______________________

Work ______________________

Cell ______________________

Medical Information

What is the Health Condition, Diagnosis or Treatment Plan for which the Patient is seeking Transitional Benefits?

Is the Patient receiving care for a Pregnancy? ☐ Yes ☐ No — If Yes, what is the estimated due date? ______________________

Is there a Surgery scheduled or recently done? ☐ Yes ☐ No — If Yes, what is/was the date of the surgery? ______________________

Is the Patient currently on a Transplant list? ☐ Yes ☐ No — If Yes, please provide a copy of the approval letter.

Does Patient have an appointment scheduled? ☐ Yes ☐ No — If yes, please indicate the date of the Patient's next appointment. ______________________

Physician Information

Physician's Name (Last, First, Middle Initial) ______________________

Phone Number ______________________

Street Address / City / State / Zip Code ______________________

Name of Facility (Hospital, DME, Group) ______________________

Date of Last Visit ______________________

Date of Next Visit ______________________

Physician's Name (Last, First, Middle Initial) ______________________

Phone Number ______________________

Street Address / City / State / Zip Code ______________________

Name of Facility (Hospital, DME, Group) ______________________

Date of Last Visit ______________________

Date of Next Visit ______________________

A Utilization Management representative may contact you to obtain medical records for clinical review.

What is the best number to reach you? Home ______________________ Work ______________________

Signature of Patient or Guardian ______________________

Date ______________________

Return to:
Christian Brothers Services / Health Solutions • 1205 Windham Parkway / Romeoville, IL 60446
HealthCustomerService@CBServices.org • 630.378.2504 (fax)