[To be printed on Fund Office letterhead]

Midwest Operating Engineers Welfare Fund
Continuity of Care Election Form

Member Information:

Name: _____ **Medical ID #:** _____ **Date of Birth:**_____

Patient Information

Name: _____ **Relationship to Member:** _____

Street Address: _____ **City, State, Zip:** _____

Telephone Number: _____

SECTION 1:

Continuity of Care Treatment: Please be advised that a Valenz Case Manager may contact you to obtain medical records for clinical review. To be considered a **"Continuing Care Patient"**, the patient must be receiving treatment for one or more of the following conditions or care. Please complete the following information for ALL treatment(s)/condition(s) that apply:

1. Treatment for a serious and complex medical condition? ☐ Yes ☐ No
   a. If Yes, please indicate patient's next appointment _____
   b. If Yes, and patient is currently on a Transplant list, please provide a copy of the Transplant approval letter.

2. Institutional or inpatient care from a provider? ☐ Yes ☐ No

3. Scheduled for a nonelective surgery? ☐ Yes ☐ No If Yes, what is date of surgery? _____

4. Pregnancy or course of treatment for pregnancy? ☐ Yes ☐ No If Yes, what is expected delivery _____

5. Terminal illness? ☐ Yes ☐ No

Additional Information: Please include any additional information that may be useful regarding your treatment/condition.

_____
_____
_____
_____
_____

SECTION 2:

Physician's Information: Please list all treating physicians below.

Physician Name	Address	Telephone No.
Name of Facility (Hospital, DME, Group)	Date of Last Visit	Date of Next Visit
Physician Name	Address	Telephone No.

Name of Facility (Hospital, DME, Group)	Date of Last Visit	Date of Next Visit

Physician Name	Address	Telephone No.

Name of Facility (Hospital, DME, Group)	Date of Last Visit	Date of Next Visit

SECTION 3:

Continuity of Care Election:

If you checked Yes to one or more of the boxes in SECTION 1, you must complete this form and return it to the Fund Office.

☐ Yes, I affirm my request to receive temporary Continuity of Care benefits beginning on the date notice is provided for up to 90 days (or less) which will end on <COCtermdate>. I understand that if I continue to use this <facility or provider>, claims for services received on or after <COCtermdate> will be processed out-of-network, resulting in a higher patient cost-share.

☐ No, I do not want to request to receive temporary Continuity of Care benefits. I understand that by choosing this election, all claims associated with this <facility or provider> will be processed out-of-network, resulting in a higher patient cost-share.

Patient's Attestation:

I, _____, hereby completed this form and attest that the foregoing statements are true to the best of my knowledge and belief. I understand that a false statement may cause medical claims to be processed incorrectly and that the Welfare Fund Board of Trustees shall have the right to recover any payments made on my behalf because of a false statement. I understand that completion of this Continuity of Care Election Form is not a guarantee of temporary Continuity of Care benefits under the Plan. I further understand and I agree to be bound by all the Rules and Regulations of the Midwest Operating Engineers Welfare Fund.

_____ _____

Patient's Name Date

_____

Patient's Signature

Guardian/Authorized Representative's Attestation:

I, _____, the Guardian/Authorized Representative of _____hereby completed this form and attest that the foregoing statements are true to the best of my knowledge and belief. I understand that a false statement may cause medical claims to be processed incorrectly and that the Welfare Fund Board of Trustees shall have the right to recover any payments made on the patient's behalf because of a false statement. I understand that completion of this Continuity of Care Election Form is not a guarantee of temporary Continuity of Care benefits under the Plan. I further understand and I/patient agree to be bound by all the Rules and Regulations of the Midwest Operating Engineers Welfare Fund.

_____ _____

Guardian/Authorized Representative's Name Date

_____ _____

Guardian/Authorized Representative's Name Telephone Number