**CONTINUITY OF CARE AUTHORIZATION**

#### Date

## *Member’s Name* *Treating Provider’s Name*

*Address* *Address*

*City, State Zip* *City, State Zip*

### RE: *Continuity of Care Request*

You filed a Continuity of Care request with *Kings County Behavioral Health* on *10/20/19.*

*Your Request has been approved.*

*You may continue your services with your out of network, or terminated mental health network provider until the earliest of:*

*•Medical Necessity criteria are no longer met, OR*

*•A course of treatment is completed, OR*

*•It is safe to transfer to an in- network provider, OR*

*•12 months.*

The Plan can help you with any questions you have about this notice. For help, you may call *KCMHP Managed Care Department Monday through Friday 8am to 5pm* at *559-852-2297*. If you have trouble speaking or hearing, please call TTY/TTD number *7-1-1* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact the Patient’s Rights Advocate Monday through Friday 8am to 5pm at 559-852-2423.

Managed Care Clinician