McLaren
HEALTH PLAN COMMUNITY

Continuation of Coverage
After Group Insurance Termination

Instructions: The former insured or legal representative should complete and submit this form within 10 days of group termination with McLaren Health Plan Community (MHP Community). After completing the form, click **SUBMIT** and you will be able to attach required documentation for your request to be reviewed.

LAST NAME	FIRST NAME	MI	MHP COMMUNITY PLAN ID NUMBER
ADDRESS			DOB
CITY	STATE	ZIP	PHONE
EMPLOYER NAME (WHERE MHP COMMUNITY INSURANCE WAS PURCHASED)			

I attest that I am a former MHP Community member and my employer group terminated or did not renew coverage with MHP Community insurance in the past 90 days. I have a medical condition that is being treated by a practitioner who does not participate with my new insurance plan ***or*** I have a condition that is excluded from my new insurance coverage as indicated below. I am requesting continued coverage for treatment with this practitioner as indicated below.

☐ I have a serious acute or chronic condition ***and*** am currently receiving treatment.
☐ My treating provider does not participate with my new insurance provider. My new insurance provider is _____
☐ The care or treatment I am currently receiving is excluded from my new insurance coverage.
☐ I currently do not have health insurance because _____
☐ I am currently pregnant
☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester

What is the name of the condition(s) you have for which you need continued coverage? _____
_____
When did this condition start? _____
Last treatment date for this condition: _____
Treatment or service(s) needing continued coverage:
☐ Office visits
☐ Diagnostic testing _____
☐ Surgical procedure _____
☐ Pregnancy care
☐ Other (list): _____
List all provider(s) you want covered under this request: _____

REQUIRED – AFTER YOU CLICK SUBMIT, YOU MUST:

- **Attach documentation verifying provider is not part of network with current health plan**
- **Attach clinical documentation from specialist to support need for ongoing care**
- **Attach a copy of the new plan Summary of Benefit Coverage (SBC)**

Signature_____ Date_____ **SUBMIT**

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