BlueCross BlueShield of Texas

Member Request for Transitional Care Benefits and Release of Information

Please complete this form if you are currently receiving medical care from physician(s) that are not listed in your provider directory and would like assistance in coordinating your medical care with the new medical plan. It may be necessary to request medical information from your current physician(s). Transitional Care Benefits, for covered services, may be available for up to 90 days after your Group's effective date of coverage. After 90 days, the Medical Director will review any requests for benefits, made in writing, according to our standard prior authorization review process.

Important ☞ Transitional Care Benefits must be discussed with a Case Management Specialist if your group contract is already in effect. Please call the Pre-certification telephone number indicated on the back of your Identification Card. Providers not in the network of your plan may still bill for charges over our allowed amount.

Group Name: _____ Group Number: _____

Employee Name: _____ ID# / SS# _____ Date of Birth: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Relationship to Employee: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: 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 a Physician appointment scheduled? Yes ☐ No ☐ If Yes, please indicate the date of the Patient's next appointment. _____

PHYSICIAN INFORMATION

Physician Name	Address	Phone #
Name of Facility (Hospital, DME, group)	**Date of Last Visit**	**Date of Next Visit**
Physician Name	**Address**	**Phone #**
Name of Facility (Hospital, DME, group)	**Date of Last Visit**	**Date of Next Visit**
Physician Name	**Address**	**Phone #**
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: _____

I hereby authorize the Blue Cross and Blue Shield of Texas Medical Director or designee to obtain any information and medical records from the above physician(s) / provider(s) in connection with making an informed decision regarding my request for Treatment in Progress (Transitional Care benefits) under the Medical Health Plan. I understand that I am entitled to a copy of this Authorization Form.

Signed: (Patient or Guardian) _____ Date: _____

Return form to:	Fax: 1-866-739-4093	Mail: Blue Cross and Blue Shield of Texas Utilization Management – Transitional Benefits P.O. Box 833874 Richardson, TX 75083-3874