# BlueCross BlueShield of Texas

## Transitional Care Request Form

Please complete this form if you are currently receiving medical care from providers that are not in-network providers under your new health plan and would like assistance in coordinating coverage for your ongoing medical care under your new plan. It may be necessary to request medical information from your current provider(s). In certain circumstances, the health plan may authorize a new member to the health plan to see an out-of-network provider at the in-network level of benefit for covered services, for up to 90 days after your Group's effective date of coverage.

**Please print legibly in black ink**

Group Name: _____ Group Number: _____

Employee Name: _____ Member ID #: _____ Date of Birth: _____

PATIENT INFORMATION

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

Address: _____ City: _____ State: _____ Zip Code: _____

### MEDICAL

Diagnosis/Treatment Plan:

_____

_____

_____

_____

**PROVIDER INFORMATION**

Name: Greater Houston Ob-gyn Dr. Camille Boon

NPI ID #: 1932377515

Phone #: 713-935-9791

Fax #: 713-600-4150

Address: 929 Gessner Suite 2150 Houston TX 77024

Date of last visit: _____ Next visit: _____

**Please check as applicable:**

☒ Pregnancy care
Estimated due date: _____

☐ Surgery scheduled or recently performed
Date of surgery: _____

☐ Transplant list
Please provide copy of approval letter

☐ Physician appointment scheduled
Date of appt: _____

**Instructions:**

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

### BEHAVIORAL HEALTH

(Mental Health/Substance Use Disorder)

Diagnosis/Treatment Plan:

_____

_____

_____

_____

Procedure Code: _____

(Absence of a procedure code will not be a basis for denial.)

**PROVIDER INFORMATION**

Name: _____

NPI ID #: _____

Phone #: _____

Fax #: _____

Address: _____

Date of last visit: _____ Next visit: _____

**Provider specialty (please check one)**

☐ MD/DO (Medical Doctor/Doctor of Osteopathic Medicine)
☐ PHD (Doctor of Philosophy)
☐ LCSW (Licensed Clinical Social Worker)
☐ LPC/LCPC (Licensed Professional Counselor/Licensed Clinical Professional Counselor)
☐ LMFT (Licensed Marriage and Family Therapist)
☐ BCBA (Board Certified Behavior Analyst)
☐ Other

**Instructions:**

Fax to: 1-877-361-7646
Attention: Transitional Care Request
Member Services phone: 1-800-528-7264

Phone: Home _____ Work _____ Cell _____

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 my new Health Plan. I understand that I am entitled to a copy of this Authorization Form.

Signed (Patient or Guardian): _____ Date: _____

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### MEDICAL

Diagnosis/Treatment Plan:

_____

_____

_____

_____

**PROVIDER INFORMATION**

Name: Memorial Herman Memorial City Hospital

NPI ID #: 1740233782

Phone #: 713/242-3000

Fax #: _____

Address: 921 N. Gessner Houston, TX 77024

Date of last visit: _____ Next visit: _____

**Please check as applicable:**

☒ Pregnancy care
Estimated due date: _____

☐ Surgery scheduled or recently performed
Date of surgery: _____

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