



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: Dr. Anne Gonzalez

NPI ID #: 1366413171

Phone #: 713-600-4125

Fax #: 713-600-4150

Address: 929 Gressner, Ste. 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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Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

MEDICAL

Diagnosis/Treatment Plan:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

PROVIDER INFORMATION

Name: Memorial Hermann Memorial City
NPI ID #: 1740233782
Phone #: 713-242-3000
Fax #: 713-338-6550
Address: 921 N. Gessner Houston, TX 77024

Date of last visit: \_\_\_\_\_ Next visit: \_\_\_\_\_

Please check as applicable:

- [X] Pregnancy care
Estimated due date: \_\_\_\_\_
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Date of surgery: \_\_\_\_\_
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