

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.

| Group Name: Member ID #: PATIENT INFORMATION Name: Date of Birth: Address: City: | Date of Birth: | |
|---|---|--|
| PATIENT INFORMATION Name: Date of Birth: | Relation to Employee: | |
| Name: Date of Birth: Address: City: | Relation to Employee: | |
| Address: City: | State: Zip Code: | |
| | State: Zip Code: | |
| MEDICAL Diagnosis/Treatment Plan: | BEHAVIORAL HEALTH (Mental Health/Substance Use Disorder) Diagnosis/Treatment Plan: | |
| PROVIDER INFORMATION Name: Greater Houston Obgyn A. Achly Heater NPI ID #: 1770826356 Phone #: 713 G35-4791 Fax #: 113 - 400 - 4150 Address: 429 Green Stute 2150 Hounton Obgy | Procedure Code: (Absence of a procedure code will not be a basis for denial.) PROVIDER INFORMATION Name: NPI ID #: | |
| Date of last visit: Next visit: | Phone #: | |
| 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 | Address: Date of last 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 Work I hereby authorize the Blue Cross and Blue Shield of Texas Medical Director physician(s)/provider(s) in connection with making an informed decision regard under my new Health Plan. I understand that I am entitled to a copy of this an entitled to a copy of this and entitled to a copy of the entitled to a copy of this and entitled to a copy of th | or designee to obtain any information and medical records from the above arding my request for Treatment in Progress (Transitional Care benefits) | |



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| Please print legibly in black ink | | | | | |
|--|------------------------------|---|--|--|--|
| | | Group Number: | | | |
| Employee Name: | Member ID #:_ | Date of Birth: | | | |
| PATIENT INFORMATION | | | | | |
| Name: | Date of Birth: | Relation to E | Employee: | | |
| Address: | City: | State: | Zip Code: | | |
| MEDICAL | | BEHAVIORAL HEALTH | | | |
| Diagnosis/Treatment Plan: | nosis/Treatment Plan: | | (Mental Health/Substance Use Disorder) | | |
| | | Diagnosis/Treatment Plan: | | | |
| PROVIDER INFORMATION Name: Mimorial Hyrman Min NPI ID #: 1740233782 Phone #: 7131242-3000 Fax #: Address: G21 A. (7000000000000000000000000000000000000 | | Procedure Code: (Absence of a procedure code will PROVIDER INFORMATION Name: | not be a basis for denial.) | | |
| Date of last visit: Next visit | | NPI ID #: Phone #: | | | |
| Please check as applicable: | | Fax #: | | | |
| Pregnancy care | | Address: | | | |
| Estimated due date: | | Date of last visit: | Novt visit: | | |
| ☐ Surgery scheduled or recently performed | | | | | |
| Date of surgery: | | Provider specialty (please check | one) | | |
| ☐ Transplant list Please provide copy of approval letter | | ☐ MD/DO (Medical Doctor/Doctor | of Osteopathic Medicine) | | |
| ☐ Physician appointment scheduled | | ☐ PHD (Doctor of Philosophy) ☐ LCSW (Licensed Clinical Social \ | Markor) | | |
| Date of appt: | | ☐ LPC/LCPC (Licensed Profession | | | |
| Instructions: | | Professional Counselor) | | | |
| Fax to: 1-866-739-4093 | | □ LMFT (Licensed Marriage and F | | | |
| Mail to: Blue Cross and Blue Shield of Texas Utilization Management – Transitional Benefit: | _ | ☐ BCBA (Board Certified Behavior☐ Other☐ | Analyst) | | |
| P.O. Box 833874, Richardson, TX 75083-3874 | S | | | | |
| | | Instructions: | | | |
| | | Fax to: 1-877-361-7646 Attention: Transitional Care Reques | st | | |
| | | Member Services phone: 1-800-52 | | | |
| Phone: Home | Work | Call | | | |
| Phone: Home I hereby authorize the Blue Cross and Blue Shield of | of Texas Medical Director | or designee to obtain any information and | medical records from the above | | |
| physician(s)/provider(s) in connection with making a | an informed decision rega | rding my request for Treatment in Progres | ss (Transitional Care benefits) | | |
| under my new Health Plan. I understand that I am | entitled to a copy of this A | authorization Form. | | | |
| Signed (Patient or Guardian): | | Date: | | | |