



PPO 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.

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.

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

Table with 4 columns: Physician Name, Address, Phone #, Name of Facility (Hospital, DME, group), Date of Last Visit, Date of Next Visit. Repeated three times.

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.

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