of Tennessee
bcbst.com

# Network P&S PPO In Network Benefit Request Form
# (Patient Initiated BEFORE Care)

-- Private --

| Patient Name | | | Patient ID Number | Patient Date of Birth |
|---|---|---|---|---|
| Patient Street Address | | | | |
| City | | State | ZIP Code | County |
| Specialty | Requested Provider's Name | | | |
| Doctor Street Address | | | Doctor PIN# or Tax ID # | |
| City | | State | ZIP Code | County |
| Beginning Date of Service | No. of Visits Requested | | Ending Date of Service | |

## Reason For Request

*(To Be Filled Out By Patient)*

*You may visit our website at **www.bcbst.com** to get participating provider facts.*

Network Availability Issue Request

- ❑ There are not any network Doctors/Hospitals available in my area
- ❑ I am new to this network *(and my Doctor/Hospital does not participate in this network)*
- ❑ Patient Preference
- ❑ Behavioral Health

Transitional/Continuity of Care Request

- ❑ Maternity Related *(Patient in second or third trimester)* Expected Delivery Date: ____________________
- ❑ Doctor/Hospital termed from network during treatment *(Doctor/Hospital must fill in the facts below)*
- ❑ Patient's network changed during treatment *(Doctor must fill in the facts below)*
- ❑ Complex medical and/or behavioral health conditions *(Doctor must fill in the facts below)*

Please include any extra comments you would like considered on your request: ____________________

Patient Signature: X ____________________ Date: ____________________

*This form must be signed by the patient to be processed. Not complete requests will be returned*

## Clinical Information to Support Transitional/Continuity of Care Request

*(To Be Completed By Provider)*

**Note to Provider:** If your request is approved, your signature below indicates that you agree to accept reimbursement of maximum allowable charges as payment in full and will bill patient only for any applicable copay, coinsurance and/or deductible.

**Note to Member:** In network benefits are paid at the maximum allowable charge set forth in your network. If your provider does not agree to accept this reimbursement amount, you may be billed for the difference.

Symptoms and Diagnosis: ____________________

Specify length of time you have treated the patient:

State clinical reasons why services cannot be rendered by a participating network provider: ____________________

You may also submit medical records you would like considered for this request: ____________________

Provider Signature: X ____________________ Date: ____________________

**This request is not valid until approved by BlueCross BlueShield of Tennessee**
**(if approved, the approved visits must be completed within 6 months of the approval date).**
**Please contact customer service at 1-800-565-9140 to confirm that your request has been approved.**
**Care rendered without prior approval will be subject to out-of-network benefits.**

Please return completed form to: BlueCross BlueShield of Tennessee, 1 Cameron Hill Circle, STE 0002, Chattanooga, Tennessee 37402-0002

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