BlueCross BlueShield of Texas

HealthSelect of Texas

CONSUMER DIRECTED HealthSelect

Participant Request for Transition of 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 the BCBSTX network provider directory for your plan and would like to apply to receive in-network benefits after transition to BCBSTX on September 1, 2017. In order to approve your request, it may be necessary for BCBSTX to request medical information from your current physician(s). Transition of care benefits for covered services may be available for up to 90 days. After 90 days, transition of care benefits will be determined by BCBSTX.

Important ☞ After submission of this form, a Personal Health Assistant will contact you within five business days on average. A formal, written, decision letter regarding your request for transition of care benefits will be mailed to you in early August (or later, if you submit the form after early August). If you have any questions regarding this form or transition of care benefits, contact a Personal Health Assistant at (800) 252-8039.

Retiree/Employee Name:____________________ Date of Birth:____________________

PATIENT INFORMATION

Name: ____________________ Date of Birth:__________ Relationship to Retiree/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

Physician 1 Name	Address	Phone #	
Name of Facility (Hospital, DME, Group)		Date of Last Visit	Date of Next Visit
NOTE: IF YOU ARE SEEKING TRANSITION OF CARE SERVICES FROM ADDITIONAL PROVIDERS PLEASE INCLUDE THEM BELOW			
Physician 2 Name	Address	Phone #	
Name of Facility (Hospital, DME, Group)		Date of Last Visit	Date of Next Visit
Physician 3 Name	Address	Phone #	
Name of Facility (Hospital, DME, Group)		Date of Last Visit	Date of Next Visit

A clinical representative from BCBSTX may contact your physician(s) listed above to obtain medical records or additional medical information related to your request.

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 (Transition of Care Benefits) under the HealthSelect plan. I understand that I am entitled to a copy of this Authorization Form.

Signed (Patient or Guardian):____________________ Date:__________

Return form to:	Fax: (972) 766-9601	Mailing Address: Blue Cross and Blue Shield of Texas 4002 Loop 322 Abilene, TX 79602