



Request for Continued Access to Providers

Please complete this form if you are currently receiving ongoing medical care from providers that are not in-network under your new health plan or have recently terminated from the BCBS network.

Select request type (please check one): Transitioning of Care (New to Blue) [ ] Continuity of Care (Special Circumstances, Existing Acnts, switching from one Provider to another, ProviderGroups/Facilities Terminating) [ ]

Please Fill in Form:

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 / BEHAVIORAL HEALTH (Mental Health/Substance Use Disorder)

Diagnosis/Treatment Plan:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

MEDICAL

PROVIDER INFORMATION

Name: \_\_\_\_\_

NPI ID #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

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

Please check as applicable:

- [ ] Pregnancy or undergoing course of treatment for pregnancy.
[ ] Surgery scheduled or recently performed
[ ] Scheduled for nonelective surgery.
[ ] Including receipt of postoperative care.
[ ] Transplant list
[ ] Physician appointment scheduled
[ ] Undergoing a course of treatment for serious and complex condition.
[ ] Undergoing institutional or inpatient care from the provider.
[ ] Having been determined to be terminally ill.

Medical Instructions: Fax to: 1-866-739-4093 I Mail to: Blue Cross Blue Shield of Texas P.O. Box 660044, Dallas, TX 75266-0044

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.

Signed (Patient or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

BEHAVIORAL HEALTH

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