BlueCross BlueShield of Texas

HealthSelect of Texas | CONSUMER DIRECTED HealthSelect

# Continuity of Care Request

Please complete this form if you are new to a HealthSelect℠ plan and currently receiving medical care from a provider(s) or at a facility(s) that is not in the HealthSelect network, or if your HealthSelect network provider or facility has recently terminated, and you would like to apply to receive in-network benefits during a time of continued care.

**Select request type (please check one):**

- ☐ New to HealthSelect with condition indicated below.
- ☐ Continuity of Care (special circumstances, or a provider group or facility leaving the network).

**Please fill in form:**

**Important:** After submission of this form, a Blue Cross and Blue Shield of Texas Personal Health Assistant will contact you within five business days, on average. A formal, written decision letter regarding your request for continuity of care will be mailed to you. If you have any questions regarding this form or continuity of care, contact a BCBSTX Personal Health Assistant at **(800) 252-8039 (TTY: 711)**.

Retiree/Employee Name: _____ Date of Birth: _____

**PATIENT INFORMATION**

Name: _____ Date of Birth: _____ Relationship to Retiree/Employee: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

**MEDICAL/MENTAL HEALTH INFORMATION**

What is the health condition, diagnosis or treatment plan for which the patient is seeking continuity of care to an non-network provider or facility?

_____

Is the patient undergoing treatment for a serious or complex condition? ☐ Yes ☐ No

Is the patient undergoing a course of institutional or inpatient care? ☐ Yes ☐ No

Is the patient terminally ill and receiving related treatment from the requested non-network provider/facility? ☐ Yes ☐ No

Is there a non-elective surgery scheduled or recently done, including postoperative care? ☐ Yes ☐ No

If Yes, what is/was the date of the surgery? _____

Is the patient receiving care for a pregnancy? ☐ Yes ☐ No If Yes, what is the estimated due date? _____

**Please provide the information below regarding the requested provider/facility.**

| Provider/Facility 1 Name | Address | Phone # |
|---|---|---|
| | | _____ |
| | | Date of Last Visit: _____ Date of Next Visit: _____ |

**NOTE: IF YOU ARE SEEKING CONTINUITY OF CARE FROM ADDITIONAL PROVIDERS, PLEASE INCLUDE THEM BELOW.**

| Provider/Facility 2 Name | Address | Phone # |
|---|---|---|
| | | _____ |
| | | Date of Last Visit: _____ Date of Next Visit: _____ |

| Provider/Facility 3 Name | Address | Phone # |
|---|---|---|
| | | _____ |
| | | Date of Last Visit: _____ Date of Next Visit: _____ |

Continuity of care for covered services will be determined by BCBSTX. It may be necessary for a BCBSTX clinical representative to request additional medical information/records from your current provider(s) related to your request. We will need your authorization prior to requesting.

What is the best number to reach you? Home: _____ Work: _____

I hereby authorize the BCBSTX Medical Director or designee to obtain any information and medical records from the above provider(s)/facility(s) in connection with making an informed decision regarding my request for Treatment in Progress (Continuation 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**