

Continuity of Care Request

Please complete this form if you are new to a HealthSelectSM 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

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